④ THE NOVA SCOTIA MEDICAL BULLETIN

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On the Road to the River

It is, some say, no harder to die than to be born. Such a statement, though it may be true, convinces no one. It is perhaps correct that one may be equally unaware of the moment of death as of the moment of birth (claimants of total biographical recall notwithstanding) provided one could fix with certainty the final biological activity that marked the time of demise. It seems though that no one, not even the most imaginative autobiographer, however brashly he may claim to recall the moment of his violent ejection into the world, has yet claimed awareness of the agonies of cell division; the strictures of ectodermal invagination or that misery of budding extrusion from the primitive gut which could be the tearing, stretching, unrecallable torture of the developing embryo.

No one, however, can practise medicine for long without observing how terrible is the patient's awareness of the days, weeks or months of the gradual destruction of a once nearly perfect body, wracked with physical pain, tortured by agonies of remorse and fear, or embittered at the God who sends him the curse of misery and death. On the other hand, one cannot practise many years without some patient, young or old, instinctively aware of the fatal nature of the illness, begging that nothing be done to prolong his misery and drag out the weary and often painful days to a merciful release. Who can observe the questioning eyes, the drawn cheeks and the wasting body and not feel a compassionate urge to do all in one's power to ease the suffering of mind and body while at the same time avoiding officious, pseudo-scientific efforts to keep alive, as an exercise in respiratory prolongation, a body in whom any hope of possible useful recovery is long past.

It should be a matter of great concern to thoughtful doctors, caring for a child with acute leukemia, to decide just what exactly to tell the stricken parents. Are we not too often guilty, out of compassion I suppose, of failing to tell the whole truth? Do we not say, softening the blow we think, that this or some new treatment offers a little hope, at least for temporary cure, without explaining that with it or without it their child will inevitably, in a few months, return to and pass through the dreadful valley whose fearful shadows deepen as you talk. Is it kindness and is it really necessary to suggest to them a treatment which we know full well is but temporary relief, because we haven't the heart to quench that tiny flame we see them trying to build into a fire of hope and knowing that as parents they are almost certain to accept whatever we suggest? If we were to tell the whole truth, would parents choose this temporary respite? It seems doubtful to me, especially if they were truly informed of the effect on their other children of prolonging the dying, the inevitable concentration on the sick one for an overly long period, the attempt to amuse and make happy during the little time remaining at any cost, even to the neglect of the others.

Writing on this subject, Witts[1] says, "More active treatment (other than blood and cortisone) raises difficult ethical questions and it should be made clear to the relations before embarking on active treatment that there is no question of cure but merely a short prolongation of life and that the side effects may be distressing." It seems reasonable that until medicine has something really worth while to offer it would be better to say truthfully that there is no effective treatment and not harry parents with unfair and painful decisions.

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If you practise much among older patients (and if you live long enough you surely will), you are struck by the eagerness with which some of those who have serious chronic and disabling, though not actually painful, illness long for the relief of an early death. You will wonder at how few of them express this desire in terms of release to the presence of the Heavenly Father whose open and welcoming arms have been the perimeter of the religious teaching within which so many of them were nurtured. I have not seen these sick old people panic or change their attitude as their disease led them more nearly to the end. Is this a deep and certain inward faith, unspoken and without the need of exteriorization in any form? Or is it merely the response of an organism aware of its failure to adapt for health and longevity, resigned like an animal to crawl away and die?

Others, however, approach their final hour with evidence of the strongest and most beautiful faith, and it is at the bedside of such as these that the observer loses fear of death himself. I recall a patient whose wife had died many years before and whose only daughter (as so often happens) had given up a life of her own to stay home and care for him. Clear in mind but with a rapidly failing circulation, he asked, "Will it be long now, doctor?" "Not long. A little while perhaps," he was told with the cautious evasion of uncertainty. The old man, more sure where the sand stood in the glass than the doctor, said, "Ask Elizabeth to come in." When his daughter, somewhat grim and gray, stood at his side he said, "Elizabeth, the doctor tells me I have not much longer to live. Have you any message for your mother?" I do not recall her reply, but the certain faith of the old man was something beautiful to behold.

I recall too sitting at the bedside of another old man dying of myocardial failure with a minimal amount of respiratory distress and a clear mind but with a pulse getting gradually weaker. It was a sort of fading such as Dickens described in the death of a child in "Dombey & Son" and which was a not uncommon termination in tuberculosis, where the vital functions gradually, painlessly and without agonizing distress progressively weaken and fail. It was noon of a sunny day and the patient said to his wife who sat holding his hand, "Put on the light Martha, it is getting dark." She, a sensitive soul, naturally empathetic, said, "Yes, in a minute or two," and the old gentleman began a quiet but clearly audible recital of the Shepherd's Psalm in the midst of which his life and those still waters slipped quietly away together. It took place without a grimace and without that frightful spasmodic gasp for air with which so many bodies, drowning in the sluggish pools of their own internal milieu, make their last futile clutch at life. No one witnessing such sweet sleep could continue to fear death.

Compare these with the macabre scenes all too often enacted in hospitals today, where the patient, possibly the victim of an incurable disease, or perhaps a worn old body seeking the road home, lies in a bed surrounded by standards from which dangle bottles of various solutions with tubing running to arms fixed firmly to boards projecting on either side of the bed as though he were nailed to a cross. A nurse stands at one side and the intern on the other is injecting a new drug that has successfully prolonged life in a small series for a few weeks and (the clincher) as long as a year in one authenticated case! The wife stands uncertainly in the doorway, wanting to be with her husband in these last hours but diffident about pushing her way through the busy traffic around the bed. When at last she wins through to his side she feels as though she were an interloper with no proper business in this place, where by simply holding his hand she can give the comfort that at the end only the presence of a dear companion can offer.

Is not all this activity to keep alive a dying man often merely an educated cruelty? Reverence for life (in the words of Albert Schweitzer) does not surely exclude respect and pity for the dying! If we have so little knowledge that we do not know when a patient is moribund, then certainly we have too little learning to use the newest chemical commended by an enterprising commerce for the treatment of incurable disease.

We hear much talk in these times, and medical voices are often raised among them, about the high costs and pagan aspects of present-day funeral rites. We however fail to see that our own ill-judged and overzealous attempts to prolong life by extraordinary measures, without regard to the privacy and intimacy of family affection in the presence of approaching death, are just as primitive as and even more barbarous than those of the undertaker, who begins the earliest phase of the morticians' "grief therapy" the moment the patient has been insufflated with his last breath and the intern has taken his weight off the splintered thorax. Here the finest sensibilities of the stricken family take precedence over all other considerations (except perhaps the value of the estate) and leave the relatives confirmed in the opinion that doctors are a cruel, heartless and greedy lot, and undertakers kind, helpful, efficient and worth their high fees!

It is difficult to discuss the economic aspects of the treatment of incurable illness or of the very aged because emotional and humanitarian factors immediately and perhaps rightly overshadow reasonable and critical considerations. In the presence of so many apparent needs or desires in our burgeoning society, how much space, time, money and personnel should be expended to keep alive for a few probably useless years an octogenarian (whose contribution to that society may never have got beyond being a consumer of food, goods, services and largesse) when so much is required for the education and nurture of young individuals who may perhaps make some worthwhile contribution to the nation? One has the feeling that though our society is geared, commercially and technologically, to youth, it is chained emotionally and economically to the aged and that out of these conflicting values is spun, from the fragile fibres of job opportunity and old-age security, an obvious and disabling national neurosis.

So also are the increasingly complicated technology and the bitterly competitive commerce, relentlessly lowering the threshold of old age until it is apparent that man no longer ages biologically or chronologically but industrially, and that these prematurely and unnaturally aged thousands must continue to be supported by the State at immense cost.

In the light of the great burden of maintaining these relatively young and healthy idlers in a state of amused well-being, where can lines be drawn in planning the treatment and care of the truly aged and the incurable?

One can begin (or can one?) with clean surroundings in a simple building within easy ambulance distance of the special facilities of the larger hospitals. One can add good nursing care, and this does not mean the miniature nurse-scientist-scrivener being foisted on the suffering public today. One can ensure medical care that is directed toward the treatment of symptoms, and those who still sneer at such management should read Modell's[2] book on the "Relief of Symptoms". Nutrition can be adjusted to the capacity and needs of the patient, and when or if deglutition becomes impossible the use of intravenous fluids in amounts calculated to relieve the distress of thirst without unnecessarily prolonging the terminal phase of hopeless disease is surely a kindness to the dying and consolation to their kin. The nasal tube presents feeding obligations which cannot be easily ignored and is in most instances a cruelty.

This is not to suggest that specific or definitive treatment, either medical or surgical, should not be given in any case, at any age, where diagnosis is clear and cure of an intercurrent condition reasonably certain, but rather to indicate that there is a precise, if difficult, position between the unnecessary prolongation of suffering through the use of nutritive fluids by extraordinary means and the easing of the agony of dehydration experienced by so many on the Road to the River, which can best be maintained by the skilful exhibition of small amounts of intravenous fluids, ordered not as a routine, but from time to time by a kindly, watchful and humane medical attendant. Thereby is some degree of ease and comfort given the traveller who makes his slow and painful descent to the Ferry, and also is administered some salve to the conscience of the scientifically trained but philosophically immature physician. □

J. W. Reid, M.D.

References

1. **Witts, L. J.:** Disease of the blood. *In:* Price's textbooks of the practice of medicine, 9th ed., edited by D. Hunter, Oxford University Press, London, 1956, p. 725.
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Crossing the Bar

Sunset and evening star,
  And one clear call for me!
And may there be no moaning of the bar,
  When I put out to sea.

But such a tide as moving seems asleep,
  Too full for sound and foam,
When that which drew from out the boundless deep
  Turns again home.

Twilight and evening bell,
  And after that the dark!
And may there be no sadness of farewell,
  When I embark;

For tho' from out our bourne of Time and Place
  The flood may bear me far,
I hope to see my Pilot face to face
  When I have crossed the bar.

– Tennyson

Death of an old Doctor

As time runs out I watch the sallowing face
Revered so many years. His skin now drawn
Like parchment on the fine straight nose; the lips
Apart as in some mirthless grin; the eyes
Grown dull reveal the fading intellect
Which seemed but yesterday to glint like ice,
So clear it was, so reasoned and so true.
I search my faith and try to comprehend
And ask why God needs to be cruel to you.
Why send this shape of slow and ugly death
That twists good men in agonies of pain
And wears them grimly out in fretful months
Or weary years of weakness and distress
That makes a mockery of sapient age
And shrinks a learned man into a babe,
A helpless creature sucking thru a straw,
His every private function public care,
Submitting like an infant to be cleansed.

Look kindly on the sudden thrust of fate
That takes a strong man at his daily task
And spares him this indignity and shame.
Mourn those who live and in your prayers to God
Beg one clear call that ends the earthly span
And summons home a spirit – still a man.

J. W. Reid, M.D.

Dr. James Allen Myrden

President 1972-1973

The Medical Society of Nova Scotia

James Allan Myrden, M.D., is a native of Halifax, N.S., and a graduate of the Dalhousie University School of Medicine. His post graduate training in surgery was taken at the Victoria General Hospital, Halifax, Peter Bent Brigham Hospital, Boston and the Royal Victoria General Hospital, Montreal.

Dr. Myrden is also a Fellow of the Royal College of Physicians and Surgeons of Canada and of the American College of Surgeons. He has been honored with a graduate research Fellowship of the National Research Council of Canada.

He is Director of Education in the Department of Surgery at Dalhousie University; Director of the Nova Scotia Tumor Clinic, and has engaged in important clinical research and experimental work, including metabolic studies in patients undergoing surgery, the arterial infusion of chemotherapy in malignancies and the clinical management of tumors of the head and neck region.

A Medical Society of Nova Scotia member for almost 16 years, Dr. Myrden has also served as Secretary to the Halifax Medical Society and as a member of the CMA Council on Health Services.

His past positions within the provincial Society include those of Treasurer, Chairman of the Finance Committee, Chairman of the Liaison Committee between the Society and Maritime Medical Care, the Membership Committee chairmanship and chairmanship of the Society's Surgical Section.

Dr. Myrden is also a member of the Executive Committee of the Provincial Medical Board.

Resident in Halifax, he and his wife Linda – a registered nursing graduate from the Royal Victoria Hospital, Montreal – have seven children. Dr. Myrden's hobbies include sailing, skiing, photography and, in his own words, "Golf . . . social golf, that is."

The President Talks to the Bulletin

THE BULLETIN: Dr. Myrden, you are assuming the presidency of the Medical Society at a time when many would feel that the initial phase of the Provincial Health Council's task is coming to an end. Perhaps you have some philosophical overview of the Health Council's actions to date.

DR. MYRDEN: Under the chairmanship of Dr. Gosse, the Health Council has provided a very real stimulus to all involved in the delivery of health services in Nova Scotia. Right now we are all awaiting publication of the Council's first report and hope guidelines for the future of the health delivery system in this province will be given.

I have no doubt there will be many recommendations on subjects about which the profession has shown concern and there may be others which could be described as controversial. I hope the Medical Society will speak strongly in support of those recommendations which we feel are in the best interests of the people of Nova Scotia and, at the same time, be prepared to deliver constructive comments on those areas considered controversial.

THE BULLETIN: What about the Health Council's future role? Do you see it playing any special part in the health delivery system?

DR. MYRDEN: Well, the Health Council was established at a time when most people felt a review of the system was urgently needed. The need for review, of course, applied and still applies across the country and is not peculiar to Nova Scotia.

Now that the initial review has been carried out, I would like to see the Health Council continue as an advisory body

to the Minister of Health on all matters relating to the health field. Certainly, a continuous review of our health delivery system is most essential.

THE BULLETIN: Speaking of the health system, one of the things everybody thinks of in relation to it is both the number of doctors immediately available and the continuing supply of physicians.

DR. MYRDEN: For a long time now we've been hearing about the shortage of practising physicians. Now, however, many hold the view that we are rapidly approaching the point where, for all practical purposes, we will soon have an adequate number of physicians in Nova Scotia.

Since the advent of MSI, many of the graduates from our medical school have entered the field of family practice. This was an area in short supply for many, many years. If the present trend continues, I am sure our needs will be filled in the not too distant future.

The situation with respect to specialists has been slowly improving over a number of years. Of course, the number of specialists in any category must be related to population. This is as much an economic requirement as it is a medical necessity.

I think we have now reached the point where the Medical Society must take a critical view of the question of whether or not we have enough physicians to meet the practical needs of the public.

THE BULLETIN: To practise, of course, a physician must be licensed. What are your views on licensing procedures to date?

DR. MYRDEN: When a physician is initially licensed to practise in Nova Scotia, he or she must meet certain medical, moral and ethical requirements. A license should not be granted for a lifetime without question. As medical science advances, a doctor's knowledge may become relatively inadequate. Or, over the years, one's moral and ethical standards may deteriorate. When such a situation occurs, it is not reasonable to expect that such a person should continue to have a medical license to practise in the province.

I feel we must address ourselves to the problem of license review on the basis of time, knowledge and moral and ethical standing. This is not an easy decision to make, but the profession has always been able to reach sound solutions to such problems in the past and I am sure it has the capacity to handle this sort of problem at the present.

Specific licensure is another matter. I personally feel we must develop those means which will allow a person to be licensed to practise in a specific field. Of course, it is difficult to define these specific fields, but we are all aware of those situations where a doctor may be deficient in certain aspects of medicine and yet truly expert in others. In order to avoid problems in the slack areas and yet take full advantage of the expertise which is available, a form of specific licensure might be worthwhile.

THE BULLETIN: This implies a decided expansion of activities by the Provincial Medical Board.

DR. MYRDEN: Yes. I feel that the PMB's activities should be expanded in the fields of license review and the assessment of physician performance.

THE BULLETIN: Of course, the rights of two people are involved here – the physician's and the patient's, or the rights of the public and of the profession . . .

DR. MYRDEN: With the present . . . shall we say "enthusiasm" . . . of nearly everybody to ensure that medical care is of top quality we must always provide the proper mechanisms to protect the rights of physicians as well as those of patients.

After all, when a physician has his license suspended or revoked, we are depriving a person of his livelihood. This must never occur without the proper assessment of good, sound evidence which will stand up in a court of law.

"I think one of the things we all have to ensure is that decisions affecting the health care of all Nova Scotians, or even of a single patient, be made on medical grounds and not for reasons of political expediency."

THE BULLETIN: Speaking of livelihoods, some people are to a greater or lesser degree deprived of their earning ability and/or financial and social resources by the aging process. CMA President Dr. Gingras made special note of the problems of the aged in his address to the Society's Annual Meeting. Do you have any opinions in this area?

DR. MYRDEN: I am convinced that the Medical Society must address itself to the problems of the aged. In so doing, we must realize that two problem areas exist. First, the

medical problems of the aged – their special medical requirements and the appropriate medical management techniques needed to meet them. The second covers the social problems. The Medical Society must be prepared to speak out on these social problems as well. However, I don't think we should encourage anybody to believe that the social problems faced by senior citizens can be solved by medical means.

THE BULLETIN: Of course, any profession as complex as medicine requires special education. What do you feel are the responsibilities of the practising physician in that field?

DR. MYRDEN: Briefly, they are considerable. The practising physician must be willing and able to impart to educators the practical needs of the profession, needs based on his daily experience.

The practising physician is probably in a better position than anyone else to determine the needs that have to be met and the particular knowledge and skills required to meet them. He should make this information known to medical educators and the best way to do this is through the Medical Society itself and through the Society's education committee.

On the matter of continuing medical education, the Society has always expressed a very real interest and I am sure will continue to do so.

The question of whether continuing medical education should be made mandatory for license is, of course, a very difficult one and it implies a process which is almost impossible to control. However, the Medical Society should explore those means whereby something like this can be carried out.

"Our members themselves must be involved in the Society through its various committees, branches and sections. It is only through the involvement of many, many people that we will be a strong Society.

THE BULLETIN: What about government's increasing involvement in the health delivery system?

DR. MYRDEN: Over the past several years government has become more and more directly involved in the delivery of health services – from assuming financial responsibility for hospital construction and administration to providing payment toward direct medical services at the patient level. With the advent of medicare, politicians have become more vocal in discussing various aspects of the system – and this is perfectly natural. Members of government have a duty to express themselves in this important area.

However, the medical profession has a duty, too. And that is the duty of a doctor to a patient. I think one of the things we all have to ensure is that decisions affecting the health care of all Nova Scotians, or even of a single patient, be made on medical grounds and not for reasons of political expediency.

The Medical Society must be prepared at all times to speak out in a constructive and positive manner when it appears that medical decisions – or decisions which directly affect health care – are being made at the government level for administrative and possibly political expediency instead of for medical reasons.

THE BULLETIN: Of course, a vital key in the system is the physician. What about the doctor's responsibilities to him or herself and, by extension, to the health system?

DR. MYRDEN: Yes, I feel this is one of the areas in which the Medical Society should take a positive position.

The fact is, doctors do work hard. In fact, they tend to overwork themselves. The physician who does this and becomes tired or ill is putting himself in a position where his ability to provide the best service possible is being compromised. I feel the day of solo practise, with long hours and one-man responsibility, is not desirable.

I think physicians should be encouraged to work in association with others in order that they may have leisure time for their families, for recreation and also for continuing education. Many doctors are finding that the group approach to medicine does allow for this and for more effective and efficient medical service.

THE BULLETIN: Today there is an increasing emphasis on social issues. What do you feel should be the Medical Society's position in this sphere?

DR. MYRDEN: The Medical Society should concern itself with the social issues of the day. One way or another, physicians have a stake in these issues whether they like it or not.

We find that in many areas social issues have medical implications. If we do not address ourselves to these issues, then we are not acting as effectively as we should. The areas in which I feel we should be acting at the present time include traffic crashes, drug and alcohol abuse, housing and population management. I think we should be prepared

to speak out on these issues whenever the opportunity arises.

Take housing, for instance. We find people crowded together, families not functioning well and, as a result, we get into the secondary problems of alcoholism and drug abuse.

THE BULLETIN: What about the future of the Medical Society itself?

DR. MYRDEN: I think the Society has been a positive force in the responsible development of our province and for the welfare of Nova Scotians, and I expect it to continue as such in the future.

We derive our strength from our members who, in addition to being physicians, are very responsible members of the community. We are free to speak out on medical and social issues – which we have done in the past and I am sure will continue to do in the future.

Our members themselves must be involved in the Society through its various committees, branches and sections. It is only through the involvement of many, many people that we will be a strong Society. □

Qualifications for Entry of the Name of a Physician in the Provincial Medical Board Register of Specialists in Nova Scotia

At a meeting of the Provincial Medical Board of Nova Scotia, held on November 25, 1972, the Board by resolution, deleted the Section usually called "Group B" of the qualifications for entry of the name of a qualified medical practitioner in the Register or List of Specialists as maintained by the Provincial Medical Board.

The regulations now read:

"The following may qualify for entry of their names on the Register of Specialists, maintained by the Provincial Medical Board of Nova Scotia:-

Qualified Medical Practioners who:-

(1) Hold the Fellowship or Certificate of the Royal College of Physicians and Surgeons of Canada; and

(2) Who have full registration for the practice of medicine with the Provincial Medical Board of Nova Scotia; and

(3) Reside in the Province of Nova Scotia"

At a meeting of the Provincial Medical Board of Nova Scotia held on November 25, 1972, the following resolutions regarding internships were approved, to become effective January 1, 1973:

I "that effective January 1, 1973, the minimum requirement for a Certificate of Internship for submission to the Medical Council of Canada to be one of the following:-

(a) a year of rotating internship

or

(b) a year of a training program in Family Medicine in which year the curriculum is equivalent to a rotation

or

(c) Certification in a Specialty by the Royal College of Physicians and Surgeons of Canada"

II "that the minimum requirement for granting a license for general or family practice be one year of appropriate general internship or an equivalent year in a family practice training program."

While these resolutions were recommended for adoption by Provincial Licensing Authorities to be effective July 1, 1974, the Board were of the opinion that in view of recent criticisms of the performance of graduates going into family medicine without sufficient hospital training in certain disciplines of family medicine, it was imperative to correct this situation as soon as possible, in order to maintain a high quality primary medical care.

As you realize, this has serious implications for members of the Class of 1973 of Dalhousie Faculty of Medicine. While the Board regrets having to take the action, the agreement to grant licenses to practice to 1973 graduates who have taken a straight internship has been rescinded and graduates who change their minds and elect to go into family practice, must conform to the new regulations and to obtain the equivalent of a rotating internship.

It also means that a certificate of satisfactory internship for the Medical Council of Canada examination will also have to meet the specifications as outlined. □

Utopia-in Medicine

Paul Kinsman, M.D.
Wolfville, N.S.

Editor's Note: *The following is an abstract of an address by Wolfville physician Paul Kinsman, M.D. Although the address itself took 55 minutes to deliver, we hope we have caught its essence in this very much shortened re-write.*

"What is man that thou art mindful of him? And the son of man that thou visitest him? Thou has made him a little lower than the angels and hast crowned him with glory and honour. Thou madest him to have dominion over the works of thy hands; thou hast put all things under his feet . . . O Lord, Our Lord, how excellent is thy name in all the earth."

It is against the background of religious tradition that I would like to project my remarks because it is the religious heritage from which the society in which I have developed has derived its morality, its humanism and its inhumanity.

Every man's outreach has its roots in his theological or idealogical orientation and his behaviour becomes an agglomeration of his inherited and his learned experiences. Bearing the onus and the privilege of a corruptible body and an incorruptible spirit, he is able to perceive his own duality; the right and the wrong of things.

Sadly, when the purpose suits us, we are oblivious to the sum of all rights and privileges that our fellow men must enjoy to ensure dignity and personal development.

Is humanity free? Does love exist?

Is Utopia achievable?

Or is society only achieving more intricate means of self-enslavement and separation from anything which resembles the Utopian ideal?

How can one dream of Utopia when we are witness to the social disintegration resulting directly from man's lack of reason, his animal nature and his continuous disregard for the dehumanizing and depersonalizing effects of the society in which we live?

While the adjective Utopian has been used to describe man's happiest plans for the reconstruction of society, its more common usage is to cynically imply the futility of such plans.

And here is the duality of man's nature: His inherent potential balanced against his hypocrisy and lack of ethics. While perceiving and appreciating true beauty, he seeks to further his own personal drive within the social group whose avowed common goal is achievement of beauty, or Utopia.

In fact, humans function in a self-oriented fashion to create, momentarily at least, their own personal Utopia. Sadly, man does not have enough humanity to translate a personal Utopia into a shared experience of benefit to all. It is the shared experience that the artist attempts in his works, the poet in his poetry, the architect in the line and function of his structures and the physician in his relationship with the patient.

Of course, the practical demands on a physician tend to preclude an appreciation of the philosophical aspects of his behaviour. A physician cannot philosophize as to the Utopian or non-Utopian frame of mind of a particular patient's assailant if, while the physician is musing, the patient bleeds to death.

But if the practical demands of the moment tend to mask the physician's humanistic philosophy we must remember that he is not a machine devoid of emotion and feeling. Early in his career the birth of a child, the tragedy of an abortion, a death, all bring him face to face with life and the natural and social pressures over which the individual in society has little personal control. Medical experience reveals more of man's spiritual nature and more of his animal nature than perhaps any other calling.

Needless to say, however, the moral issues become secondary to the practical medical needs of the moment.

Indeed, I think this tends to support my concept that Utopia is a very individual state, won or lost on the battlefields of loneliness. Whatever a human being's origins, it is in the ultimate moments of stress that he or she responds in a totally self-oriented manner with little or no regard for the state of being of others.

This, unfortunately, has tended to condition society so far away from the concept of good that it may be unable to realize that a Utopian concept can exist on a broader base than that of momentary or continuing individualism.

In medicine two people are involved – the physician and the patient – and here I believe it is possible through the physician-patient relationship to understand and approach a true Utopian concept of responsibility, understanding, co-operation, trust, and mutual help. And it is important to note that a value judgment of the *total* picture of health delivery can only be made through the assessment of the personnel involved and the nature of the health needs of the recipients, keeping in mind that both groups are human beings subject to the traditionalism inherent within the social order from which they have developed.

It is a question of understanding the perspective which must be assumed by the physician in assuming his responsibilities to society.

Health professionals are constantly faced with the question of the direction of the society in which we live. What health needs does its evolving structure create? No one has yet come up with a total answer.

Evidence abounds of individual depersonalization as patients become numbers and punched computer cards. On a broader scale humanity still glories in war and the development of means for social destruction and there is also ample evidence of man's apparent lack of interest in his own welfare as illiteracy, pollution, the population explosion, and hunger underline man's disinterest in co-operative effort toward the common good.

Yet, in spite of the individual's self-orientation, man still seems to need interpersonal relationships of a support nature — family, common interest groups, clubs, states and nations — and the loss of these results in a loss of individual stability. This does not contradict the concept of individuality, however, because in the democratic system there is still room for individual endeavour within a workable unit.

But, the profound question is, do we have in our society the type of humanism profoundly understood and deeply felt in the heart, the kind of humanism which overrides particular political, philosophical and religious systems to concern itself with man as man? Does western civilization contain any feeling? Is there any pity for the undeserved misery of the exploited poor or for those whose life has been shattered by illness, either acquired or congenital?

Now, the Utopian mutual help concept can be approached by the physician and patient through the avenue of man to man confrontation and interrelation which medicine provides. True, an absolute medical Utopia in terms of complete victory over illness could result in race suicide through over-population and subsequent starvation. But this might be an overly simplistic inference, because the medical Utopia would also have to concern itself with birth and population control, genetic purification, euthanasia, etc. and, indeed, the total picture of who has the right to live and produce in our society.

By today's standards, however, there are no indications that this concept could ever be brought to social awareness, particularly if we recognize the current massive social disregard for crying medical needs met only by government action based largely on political expediency over human need.

I believe that Utopian medical services must be based on the love of man for his fellow men. But man can and does lose himself in hate. Look around yourself. If one can lose oneself in hate, can one know anything of love. And, surely, is not love an integral part of the Utopian concept?

Let's leave philosophy for the moment and consider the practical factors in the direction taken by organized medicine in Nova Scotia today.

Government involvement in the health care field has not only challenged the traditional role of the physician as the health care fulcrum but, in some provinces, has drastically altered his role, making him or her nothing more than a team member in the delivery of health care or an equal-status board member with non-professionals in its administration.

Social change is, of course, an on-going process, one which has only recently begun to affect the medical community. One thought which comes to mind immediately is this: Is indeed the wish to maintain the one-to-one physician to patient relationship predicated on the profession's resistance to change or is it because physicians recognize that this is the most effective way to provide medical services?

I believe the Medical Society of Nova Scotia, at least, firmly believes in the personal responsibility principle — the traditional doctor-patient relationship — and has stated clearly its intent to support government only in so far as the best interests of the people are concerned, holding firmly to the principles of quality care as opposed to systems which may have only political expediency to recommend them.

To the benefit of Canadian organized medicine the response to government and public scrutiny has been largely constructively co-operative. The dangers of excessive introspection by the profession have so far been avoided and government-profession confrontations have been kept in perspective by both parties.

Being human and holding both professional and political responsibilities — as do their fellow Canadians — physicians are responsible for the protection of both their professional integrity and the rights of the public they serve — the latter in a far more direct and personal way than through political means.

Logically then, stands based on experience must be taken within the profession even at the risk of being accused of rigidity.

Government, too, bases its views of health care delivery on experience and the advice of the profession, but relates its stand to political implications while the quality of care at the individual patient level becomes secondary — however strongly words are uttered to the contrary.

To stress and support professional responsibility to quality of care, the profession in Nova Scotia must speak as a unit.

The Medical Society deserves to be commended for its sincerity of effort in presenting an objective submission to the Health Council in response to pressures to impose a medical care delivery system from above. However, government intervention has tended to encourage an almost paranoiac introspection in some segments of the profession; a destructive force drawing the profession's attention away from actual service at the patient level and concentrating it on the mechanics of the system. This is not totally bad, but it is a matter of degree and should never reach the point where the profession governs its actions only in response to real or imagined public pressure.

If public pressure is such that a forced and regressive physician role modification takes place, then the public must, in part at least, take the responsibility for whatever deterioration occurs in the quality of care available.

At the same time, the profession must be held responsible for permitting the ethic of personal responsibility to be diluted and the basic humanism of a one-to-one relationship in a very personal sphere to be qualified or even destroyed.

There can be no progress toward a Utopian concept of health care if the quality of the physician himself is subjected to downgrading forces.

The medical profession is a group of people subject to all the common frailties of the human race ... but with enormous responsibilities.

As a group, then, it must forcibly police itself, encouraging and indeed forcing, its members to adhere to true quality in the delivery of health services. The profession must retain its humanity, its humanism. In spite of government pressure toward depersonalization, the physician must have time to develop a relationship with the patient based on mutual trust and respect. Each physician must assess himself in the light of what logically appears to be the ultimate good; that is, the welfare of human beings and the world. There can be no substitute for honesty with oneself.

In conclusion: I have attempted to show first that Utopia cannot exist as a human social order. Secondly, I believe that man individually experiences moments of Utopia and, thirdly, whether in medicine or any other field, I believe man can strive toward a universal understanding of his personal Utopia by showing love for his fellow man and committing himself to the exercise of responsibility in his personal and interpersonal relationships. □

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Blood Gas Analysis

A. R. Macneil,* M.D., M.Sc., F.R.C.P.(C), J. G. Holland,* M.D., F.R.C.P.

Halifax, N.S.

Due to the recent increase in the number of centers having the capability of performing blood gas analysis, this series is offered to familiarize the physician with the interpretation of results.

pH	– 7.240	The blood is arterial.
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Base Excess	– 15.3	concentration is 21%
Standard Bicarbonate	– 12.8	(room air).
PO_2	– 90.0	

Write your interpretation

Turn to page 38 and check your answer

*Dalhousie University, Department of Medicine, Pulmonary Laboratory, Victoria General Hospital, Halifax, N.S.

Some Thoughts on Re-Licensure or Re-Certification*

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Halifax, N.S.

In this day when in Canada medical care is financed by tax dollars it is but logical that the public should wish to be sure that they are receiving full value for their money.

One hears constantly within the ranks of our profession, from other branches of society and from Government, that the obvious answer to this problem can be provided by some form of licensure which must be renewed periodically. Usually discussion stops at this point – which in fact is where it should really begin!

In some discussions the matter is carried further – to the point that "satisfactory evidence of continuing medical education" must be provided for renewal of license. This falls down because evidence of attendance at a meeting is no guarantee that most of the meeting time was not spent on the golf course. So sooner or later we arrive at the conclusion that some form of evaluation of the doctors performance must be undertaken.

At the present time recall knowledge is the only facet of the doctors performance that can really be objectively evaluated to an adequate degree. The half-life of medical knowledge is now considered to be about five years. Thus, if some such yardstick is applied all of us who are not able to continue our medical education will fail the examination after not more than 5 years.

It is apparent that recertification and continuing education must be closely linked. For a proper program two things are needed:

1) An effective program of continuing medical education which can be made available to all doctors.
2) An objective method of evaluating the quality of patient care delivered by doctors – that is, how well they look after their patients.

At the present time, in Canada we have neither. Although programs of continuing education for the most part based on the Universities have developed and increased steadily in scope we are still a long way from the point where we can say to a solo practitioner in a remote area "Come into the University Centre for a period of "X" weeks every "Y" months for a refresher course. We will provide a substitute to look after your practice."

Until some such arrangement can be provided the favoured who practice close to the source of continuing education will have such an advantage over their colleagues in more distant areas, that any program of recertification would be grossly unfair.

The matter of evaluation of the quality of delivery of health care is under study by the American Board of Internal Medicine and National Board of Medical Examiners supported by grants from the Carnegie Foundation and the Commonwealth Foundation. The American College of Physicians at the request and with the support of Dept. of Health Education & Welfare of Government of the United States is studying methods of evaluation of the performance of physicians in Community Hospitals. Our own Canadian Council on Hospital Accreditation is applying for a National Health Grant to study this whole problem.

It is generally agreed by those who have studied the matter that any form of Peer Review or Medical Audit now in use is inadequate for purposes of recertification and relicensure. But it is also evident that what we really want to know is how well the doctor cares for his patients. It is to be hoped that the studies now underway will provide the answer.

Meanwhile, we should consider our philosophy in regard to this most important matter. In this regard it is worthwhile considering what has gone on in the past and what is being done elsewhere. As far back as the Code of Hammurabi (2270 B.C.) the earliest known legal code, there is evidence (Article 218) of attempts to control the quality of the delivery of health care by the punitive approach. Again the physician who looked after Alexander the Great in his last illness was crucified. Yet Alexander is reputed to have died of malaria for which effective treatment was not discovered until nearly 2000 years later. The punitive approach certainly did not help Alexander and the Macedonian Army probably lost its best physician.

I have had the good fortune to hear this matter debated by the Board of Regents of the American College of Physicians on several occasions. They fully support the stand of the American Board of Internal Medicine – that a periodic, voluntary, non-punitive, educational program of re-assessment or recertification should be introduced.

To this view, I fully subscribe. Those of you who have taken either of the Self-Assessment Programs of the American College of Physicians will agree, I am sure, that it was a somewhat horrendous experience, but of tremendous educational value. I believe that this is a place where the "carrot" rather than the "stick" is to be preferred.

In February, 1971 an Ad Hoc Committee of 4 members appointed by the American College of Physicians and four appointed by the American Board of Internal Medicine

*Presented to Halifax Medical Society, February 1972.

**Professor and Head, Department of Medicine, Dalhousie University.

recommended as follows to the BOARD OF REGENTS of the American College of Physicians:

1. That recertification was certainly obviously on the way and it could not be avoided. It was agreed, however, that recertification could not be accomplished effectively or objectively by any sort of credit for attending meetings, reading, etc.

2. As far as content of any examination is concerned, it was felt that this should test the internal medicine specialist's clinical ability to care for patients. The exact form of such an examination is being studied at the present time and will continue to be under study by the Board. The possibility that it could be an "open book" type of examination was discussed. It might very well be the type of examination being studied by the National Board of Medical Examiners and the American Board of Internal Medicine. This examination is called the computer-based (patient simulation) examination. The Carnegie Foundation and the Commonwealth Foundation have given a grant to American Board of Internal Medicine and National Board of Medical Examiners for a three year study on this method of examination which has some hope of being more related to clinical competence than to knowledge.

3. The possibility of peer review or some form of medical audit was discussed in great length. No one could present evidence that peer review or medical audit was at a stage where a man could be certified or recertified at the present time. All studies in this field will be watched with great care and there is a possibility that this might eventually be another method of doing recertification.

4. It was felt that a man who takes a recertification examination and fails should be able to take it every year hoping that he will eventually pass. It was also agreed that nothing would be done to his original certification on whether he passed or failed the recertification examination.

5. Anyone who passed the recertification examination would not be permitted to take it again for a minimum of about 7 years.

6. The American College of Physicians would continue to do all it can and even more to help the man who failed. There are a number of ways this could be done and this will be a continuing responsibility of the American College of Physicians.

7. Recertification was considered a satisfactory term and could not be described any more accurately or more satisfactorily by any other word.

8. The American Board of Internal Medicine is strongly urged to give the matter of recertification continuing study and to move ahead with designating a committee which will have the responsibility to develop the method, the timing and other things connected with the recertification procedure. It should be emphasized that the American Board of Internal Medicine would be offering to recertify specialists and not requiring specialists to be recertified.

9. Any official announcements should be made only upon mutual agreement between American Board of Internal Medicine and American College of Physicians.

In conclusion, Mr. President, I would urge you not to adopt the policy put forward tonight but rather to:

1. Continue with efforts to make satisfactory programs of continuing education available to all physicians.

2. Press forward in efforts to evolve a satisfactory method of periodic, voluntary, non-punitive, educational, reassessment available to **ALL DOCTORS.**

3. Develop a method of re-assessment that tests the doctors ability to care for his patients and not merely his recall knowledge.

4. Devise some prize such as a seal on his original license given to the successful candidate rather than removal of license from the unsuccessful candidate. □

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Patient, Bed and Bathroom **(continued from page 25)**

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Laying it on the Line

CMA PRESIDENT, DR. GUSTAVE GINGRAS ADDRESSES THE SOCIETY

C.M.A. President Dr. Gustave Gingras underlined his reputation for straightforward comment when, in an address to the 119th Annual Meeting of the Medical Society of Nova Scotia, he touched on the preliminary points of CMA agreement and dissent with the Hastings Community Health Centres report and, later, on the profession's responsibility in the field of self-imposed discipline, and his contention that "there are far too few physicians and allied health workers prepared to dedicate their professional lives, or a major portion of it, to care of the elderly."

Based on preliminary studies, Dr. Gingras said, CMA agreed with several positions and opinions of the Hastings Committee, notably that "the present health care system has defects which prevent, or render difficult, the provision of comprehensive health care to a fully insured public." The co-ordination of health manpower and facilities and a more effective integration of health care and social services are, he said, "not only required but essential."

He said there could be no argument with the report's contentions that economies within the system must be realized but, he noted, "It is conceivable that the emphasis on developing a single health care and social service system, incorporating a significant number of community centres, may result in considerable regimentation of the public. There is also a great, and indeed almost certain, risk of creating undesirable depersonalization of health care and social services."

Dr. Gingras reiterated concern over the lack of evidence that a single health and social service system based on community centres would either reduce costs or their rate of escalation.

He pointed out that the Hastings Committee itself had admitted that a true assessment of the community health centre concept was difficult because the full operating concept as proposed in the report does not exist. CMA, Dr. Gingras said, felt such centres should be established in areas where health and social services are presently lacking and, if they prove successful, "the program should, indeed, be expanded."

In dealing with the question of salaries as opposed to fee-for-service in such centres, Dr. Gingras reminded Nova Scotia physicians that CMA "is not unalterably opposed to salary or other forms of remuneration for medical services" but he stressed that "in most areas fee-for-service is an effective method of financing most medical services."

Dr. Gingras also tackled the problem of increasing public criticism of the profession, saying, "Today, it is almost rampant." Experience, he said, had taught him that a great many of the accusations of inferior personal medical care are invalid but, he said, "I can assure you, on the other hand, that some are terribly justified."

In meeting the best interests of the public as a whole, the CMA President said, regulatory bodies in the health care field and their professional members enjoyed a right which brings with it "much responsibility, a considerable duty and immense obligations."

Stressing that justice must not only be done, but also be seen to be done he called for the inclusion of knowledgeable non-physician representatives in health boards and colleges.

Dr. Gingras recognized that the public was not fully aware of the criteria under which licensing and discipline within the profession operates but that the public does have a right to know that the profession's responsibilities in this area are being met and "The public has a right to know if a physician is ruled to be incompetent."

"The public", he said, "asks why the medical act and the college which it establishes to enforce it can keep such information confidential – secret even – from the unsuspecting patients who consult that particular physician?"

He added, "They cannot understand why – and, quite frankly, I too have some difficulty with the logic of the situation."

Dr. Gingras also pointed out that there are now nearly two million Canadians over the age of 65 and made a direct appeal for increased interest in the health problems of the aged by the profession saying, "I very strongly suggest that you look with favor on the seal of gerontology", and he noted that the gerontologist "more than any other practitioner will require balanced judgment, abundant sympathy and understanding as well as the patience required to listen, I repeat, to listen to and appreciate the patient's problems. For our younger physicians with an increasing interest in the humanistic aspects of medicine versus the pure science of medicine, gerontology provides a challenging opportunity." □

MEDICAL AUDIT-TY

"We are the best selected few
And all the rest are damned.
There's room in heaven for me and you
But we can't have heaven crammed."

– Anon.

Management of Solitary Metastases to Lung and Mediastinum

M. T. Casey,* M.D.
Halifax, N.S.

In the management of a patient with malignant disease, whether it is at the time of the initial diagnosis, or in later follow-up, the doctor must decide if this particular patient is a candidate for cure or a candidate for palliative treatment.

Obviously the ideal in the treatment of any patient with a malignancy is the total eradication of all malignant disease and in many cases this goal, if it is to be achieved, justifies certain major procedures which would not be considered if one felt that the patient had no hope of being cured.

Certain criteria have evolved in assisting the doctor to determine the extent of the disease and into which category a specific patient falls.

If the doctor feels that the primary malignant disease is confined to a local area there is a feeling of optimism and the hope that the disease may be totally eradicated either with surgical excision or radiation. On the other hand the presence of a metastasis or a secondary tumor remote from the primary site leads to a feeling of pessimism and one tends to categorize such a patient as a candidate for palliation only and the clinician does not feel justified in carrying out a major procedure to remove the tumor from the secondary site because of the strong possibility that removing such a tumor still does not eradicate all the tumor from the patient.

Experience over the past forty years, however, has shown that there are selected cases where a secondary tumor may be demonstrated in the lung or mediastinum and that such a tumor may represent a solitary metastasis. In such cases, thoracotomy with removal of this involved portion of lung tissue or mediastinal mass may accomplish the original aim of the doctor which is complete removal of all malignant disease from the patient.

The clinician must make the decision, if this is indeed a solitary metastasis or whether it merely represents the first of many metastatic deposits which will ultimately cause the death of the patient. Obviously the management is quite different in the two cases.

How may one decide whether an aggressive approach with thoracotomy and pulmonary resection is justified or whether the candidate should be treated more conservatively and give up the hope of cure? Obvious questions occur to the doctor.

Is the primary cancer under control?

Is the pulmonary lesion a malignancy?

Is the pulmonary lesion a primary or a secondary malignancy?

Are there other metastases present in other organs?

In assessing the patient, tomograms of the lung may show the presence of tumor deposits which have not been evident on the ordinary film. Alkaline phosphatase, liver scan, bone X-rays and bone scan may show the presence of tumor deposit which had not been suspected and which were not symptomatic.

If one does suspect that this tumor is indeed a solitary metastasis and that such a patient might be cured by having a resection, is there any harm in deferring definitive surgical treatment while awaiting the appearance of other deposits to manifest themselves? The answer to this is, "Yes", there is harm in deferring treatment. Once the metastatic deposit has appeared in the lung it may then behave as a primary cancer of the lung, with its proclivity to spread to the hilar nodes or by the blood stream to other organs. One would not defer treatment of a primary lung cancer indefinitely and the same applies to a solitary deposit in the lung.

Statistics compiled have shown that certain primary tumors in certain organs are more likely to give rise to one solitary deposit in the lung than are primary malignancies in other structures. Such information assists the clinician in determining into which category he should place his patient.

Certain terms have appeared in the journals which make communication easier. The terms, synchronous, precocious, and metachronous are used in describing the time at which the pulmonary metastasis is first demonstrable. These adjectives are self-explanatory. It has been observed that the longer the time interval between the treatment of the primary malignancy and the appearance of the "solitary metastasis" the more favorable the prognosis.

While isolated reports of resection of solitary pulmonary metastases appeared as far back as forty years ago, with the increasing numbers of such procedures being reported in recent years, certain patterns are seen to be emerging which assist the doctor in deciding which metastasis is likely to be a solitary one and what the behaviour of these solitary metastases might be.

As far back as 1947, in a review of 24 cases by Alexander and Haight[1], a greater survival rate was found in patients with sarcomas than in patients with carcinomas.

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In fifty-five cases in children ranging in age from three months to fifteen years reviewed by Kilman and Kronenberg[2] where most of these patients had sarcomas a 36% five year survival rate was reported in patients undergoing one or more thoracotomies with pulmonary resection. Thirty-one of these fifty-five cases were Wilms' tumors. It was recommended by these authors that when the pulmonary metastasis is first observed chemotherapy should be the first form of treatment for the metastasis if the tumor is known to be sensitive to a chemotherapeutic agent. If the lesion does not disappear, then a pulmonary resection is recommended.

A relatively optimistic picture is presented by Sweetnam and Ross[4] who reported on twelve patients, ranging in age from ten to fifty-two years, all of whom had bone sarcomas with subsequent pulmonary resections for primary metastases; there were 66% survivors with an average survival time of over six years.

From the same centre, Ann Arbor, where the series of twenty-four cases was presented in 1947, a second series was presented in 1971 consisting of 68 cases[5]. Of these 68 cases, 40% had an overall survival rate greater than five years and as in the 1947 series a slightly greater survival rate was noted in the sarcoma patients. It was also observed that palliative resection had no effect on the survival rate over those patients who had a pulmonary metastasis which was not resected.

In the many series available for review in the journals during the past twenty years, the recurrent question is found: "Is this a solitary metastasis?" Various recommendations, usually quite arbitrary, are found. There certainly is a reluctance to subject a patient who is ultimately going to die with malignant disease to the needless discomfort of a major surgical procedure which could be lifesaving.

An attempt was made to define more precisely the criteria for operability by Joseph, Morton and Adkins[6] in 1971 in a series of 113 cases. These authors described a technique for measuring the "tumor doubling time". A technique is described where the size of the tumor can be measured radiologically and the number of days required for this tumor to double its size can be recorded and a graph prepared. A definite correlation was observed between the time required for the tumor to double its size and the survival rate. The natural history of untreated pulmonary metastases was observed in 89 patients who were not subjected to resection. In patients whose tumor doubling time was observed to be forty days or more, the survival rate was much greater than in those whose tumor doubling time was much shorter. Of fourteen patients

TABLE
Pulmonary Metastasis

Name D.o.b. Sex	Date and Site of Primary Disease	Date and Site of Chest Metastasis	Definitive Treatment and Date	Follow Up
M.W. 1906 F	Carcinoma of bladder, March, 1967; Carcinoma of colon, 1963.	June 1967, left lower lobe.	Left lower lobectomy June 1967.	Alive and well. November 1972.
M.P. 1910 M	Right kidney adenocarcinoma, 1966. (Symptoms present three weeks). Right nephrectomy November 1966.	June 5, 1968, right upper lobe. November 1968, left lower lobe, Patient watched until February 7, 1969.	Right upper and middle lobectomy, June 18, 1968, showed secondary carcinoma in lung from primary in kidney. Left lower lobectomy done. Diagnosed as secondary carcinoma in lung from primary in kidney.	Alive and well. November 1972.
S.S. 1947 F	Left leg, Diagnosis: Fibrosarcoma, treated by amputation of leg in 1963.	August 1971, massive mediastinal mass.	Thoracotomy with removal of mediastinal mass and right lung.	Patient expired Sept. 7, 1972, with demonstrable metastasis.
H.L. 1947 F	January 1970, Fibrosarcoma of buttock.	January 1972, mass in the right upper mediastinum.	Excision biopsy plus radiation. Thoracotomy with removal of secondary fibrosarcoma from mediastinum.	Patient alive and well. November 19, 1972.
U.C. 1918 M	Left kidney adenocarcinoma.	May 1, 1972, 2 to 3 cm. lesion in the right lower lobe.	Left nephrectomy January 1965 (history less than one week; pathologist reported invasion of renal veins). Thoracotomy on May 10 showed pleural metastasis.	Patient lost to follow up.

whose tumor doubling time was over forty days, in spite of their slow growth and presumptive better prognosis 100% of these patients were dead in less than two years. This gives added evidence that the metastasis if left untreated will kill the patient and not merely lie dormant for many years.

A plea is made by these authors for an aggressive approach in patients with a long tumor doubling time.

A review was made of five cases whose primary malignant disease was apparently controlled but who were found on follow up to have metastatic disease in the chest. These cases are summarized in the table.

Summary and Conclusion

While there is a justifiable feeling of pessimism when one demonstrates the appearance of even a solitary remote metastasis in a patient whose malignant disease appeared to have been cured, certain selected cases are candidates for aggressive treatment, including thoracotomy, with the justifiable expectation that such treatment may be successful in eradicating all malignant disease.

This paper should also indicate the value of careful follow-up even after many years so that early recognition of a potentially curable metastasis might be made. □

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Physician Self - Assessment

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The following questions have been submitted by the Division of Continuing Medical Education, Dalhousie University, and are reprinted from the American College of Physicians **Medical Knowledge Self-Assessment Test No. 1** with the permission of Dr. E. C. Rosenow, Executive Vice-President.

It is our hope that stimulated by these small samplings of self-assessment presented you will wish to purchase a full programme.

DIRECTIONS: Each of the questions or incomplete statements below is followed by five suggested answers or completions. Select the ONE that is BEST in each case.

335. Drug fever may be ruled out as a cause of persistent fever

(A) if eosinophilia is not present
(B) if temperatures exceed 40.0 C (104.0 F)
(C) if fever persists for 24 hours after the drug is discontinued
(D) if other manifestations of an allergic reaction are not present (e.g., rash, joint symptoms)
(E) by none of the above

401. The first step in the diagnosis of the malabsorption syndrome is to establish the existence of steatorrhea. Steatorrhea, hence malabsorption syndrome, is unlikely if

(A) daily stool weights do not exceed 150 grams
(B) d-xylose excretion in a 5-hour urine is more than 5 gm after an oral load of 25 gm
(C) serum calcium is greater than 9.5 mg/100 ml
(D) roentgenogram of the small bowel is normal
(E) the patient has not lost weight □

(Please turn to page 35 for answers)

Nisseria Infection in an Appendectomy Incision

A. S. MacDonald,* M.D. and J. C. Johnson,* M.D.

Halifax, N.S.

That gonorrhoea may occur outside the urogenital tract is well known and a constant proportion of gonococcal infections are made up of gonococcal pharyngitis, conjunctivitis, hepatitis, arthritis, endocarditis and dermatitis. Disseminated gonococcal infections with high fever, rash and arthritis are not rare. However, a post-appendectomy wound infection with gonococcus had never been seen by any of the surgical or gynecological staff at the Victoria General Hospital and a search of the literature was not helpful. Because of the rarity of this complication it was felt justifiable to report this single case.

Clinical data:

A 21 year old girl was admitted to hospital with complaints of abdominal pain which had begun 8 hours previously. Initially it was in the mid-abdomen and was associated with nausea and vomiting. After some hours the pain localized in the right lower quadrant. The patient had finished what was described as a normal 5 day menstrual period the day before. She had also been treated 2 weeks previously with antibiotics for 7 days because her boyfriend had been found to have gonorrhoea. She last had intercourse with him 2 months prior to this treatment and had no sexual contacts since nor had she any genito-urinary symptoms. She was treated with tetracycline because of an allergy to penicillin. On examination on this admission she was found to have tenderness and guarding in the right lower quadrant of the abdomen. Rebound tenderness was elicited and bowel sounds were diminished. Rectal and pelvic examinations were negative. Her temperature was 101°F. and the white blood cell count was 16,750 per cu. mm. with 77% polymorphs.

A diagnosis of appendicitis was made and operation was performed through an incision in the right lower quadrant of the abdomen. A non-inflamed fibrotic appendix was removed. The right tube and ovary looked mildly inflamed. The left tube was not visualized. Post-operatively the patient's fever subsided and the wound appeared to be healing well. She was discharged on the fifth post-operative day. Two days later she again became febrile and an abscess was found and drained of a brownish watery material. She was re-admitted to hospital and numerous cultures were taken but failed to grow any bacteria. She complained of pain in the right upper abdomen, aggravated by breathing and of generalized malaise. Fluoroscopy of the diaphragm was normal. A gall bladder series initially showed non function but a repeat was normal. The wound was treated locally with Dakin's solution but healed very slowly. Intravenous tetracycline was given for 5 days. She was discharged with the wound slowly granulating. The final culture reported after discharge revealed Nisseria species, presumably gonorrhea. The wound remained indolent until the patient was placed on erythromycin following which it rapidly healed.

Discussion

This case raises several interesting problems. The first is the route of infection. We believe that it was most likely direct contamination at the time of surgery although there was no obvious pus or free fluid in the peritoneal cavity. The occasional occurrence of similar abscesses in episiotomy incisions favours this explanation. In support of this was the development post-operatively of right upper quadrant tenderness and diaphragmatic irritation, the so-called perihepatitis of Fitz-Hugh Curtis, which often occurs consequent to acute pelvic inflammatory disease. It is also possible that the bacteria were blood-borne although gonococcal septicaemia is usually accompanied by a haemorrhagic rash, spiking fever and arthralgia. None of these occurred in this patient. A final possibility is that the infection was due to accidental inoculation of the wound by the patient herself or from her clothing. A second unusual feature is the persistence of the infection despite an adequate course of tetracycline therapy a short time previously. The patient was adamant about lack of possibilities for re-infection and the failure to respond to intravenous tetracycline on her second admission would tend to confirm her innocence. Another point worthy of note was the nature of the drainage. It was thin and watery, dirty brown in colour and odourless. The extreme susceptibility of Nisseria gonococcus to exposure explains the inability to grow anything in culture as transport media was not used initially.

When patients suspected of appendicitis are found at operation to have acute salpingitis they are usually treated post-operatively with penicillin. This may explain the rarity of this complication but with the incredible increase of gonorrhoea especially of the antibiotic resistant variety, among the young adult age group, it may become a frequent occurrence. □

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*From the Department of Surgery and the Student Health Service, Dalhousie University and the Victoria General Hospital, Halifax, N.S.

"I have never had a policy. I have simply tried to do what seemed best each day, as each day came."

Lincoln

THE MEDICAL SOCIETY OF NOVA SCOTIA

PROCEEDINGS OF

8th MEETING OF COUNCIL (1972)

AND

119th ANNUAL MEETING

The first session of the 8th Meeting of Council began as the Officers attired in academic gowns, accompanied by Dr. Gustave Gingras, President of The Canadian Medical Association, paraded through the Medical Exhibit Lounge and Council Chambers to the head table. At this point, Dr. P.B. Jardine, Chairman of Council, called the meeting to order. Dr. G.W. Turner, President, welcomed those present at Council, introduced the Society Officers to Council and called upon Dr. Gingras to address the members. Dr. Gingras brought greetings from the Canadian Medical Association and wished the members well in their deliberations. Pointing to a number of the issues contained in Reports to Council, Dr. Gingras expressed pleasure at the extent to which the Society was involving itself in such matters as the reproductive care program, the traffic crash problem, public health issues, all of which pointed to a meeting with a high potential of productivity. Dr. Gingras asked the members to call upon him at any time for information they might require.

Guests of the Medical Society to whom Dr. Jardine extended a warm welcome included Hon. Gerald A. Regan, Premier of Nova Scotia; the Hon. D. Scott MacNutt, Minister of Public Health; Dr. G. Gingras, President, Canadian Medical Association; Dr. F.P. Duff, President, Newfoundland Medical Association; Dr. R.B. Eaton, President, New Brunswick Medical Association; Dr. R. M. Mundle, President, Prince Edward Island Medical Association; Mr. S.S. Jacobson, Chairman, Medical Care Insurance Commission; Mr. A.N. Sarty, Chairman, Nova Scotia Hospital Insurance Commission; Mrs. Margaret Bradley, President, Registered Nurses' Association; Dr. D.A. Eisner, President, Nova Scotia Dental Association; Mr. A.B. Balcom, President, Nova Scotia Hospital Association; Dr. G.G. Simms, Deputy Minister of Public Health; and Dr. N.P. DaSylva, Secretary, Canadian Medical Association.

Dr. Jardine welcomed the Exhibitors noting that the Society recognizes their contribution to the Society's Annual Convention. Dr. Jardine encouraged Council members to take every opportunity to visit the displays and discuss the products with the Exhibitors' Representatives; he noted that the Exhibit Representatives would be attending the Friday Luncheon as well as the Banquet and Ball as guests of the Medical Society.

Dr. Jardine addressed Council briefly on the order of business and presentation of reports.

Dr. R.F. Hand, Chairman, Medical Archives Committee, read the names of Society members deceased during November 27, 1971 and November 23, 1972 as follows: Dr. R.L. Aikens, Halifax; Dr. R.T. Annand, Bridgetown; Dr. D.A. Campbell, Bridgewater; Dr. M.F. Fitzgerald, New Glasgow; Dr. C.K. Fuller, Yarmouth; Dr. N.H. Gosse, Halifax; Dr. A.S. MacIntosh, Halifax; Dr. P.S. Nigam, Halifax; Dr. V.D. Schaffner, Kentville; Dr. O.R. Stone, Bridgetown; Dr. J.R. Greening, Antigonish. Council observed a period of silence in tribute to the memory of these members.

New membership applications totalling 57 were approved by Council.

The Transactions of the 7th Meeting of Council and the 118th Annual Meeting (1971) as printed in the February 1972 issue of the Nova Scotia Medical Bulletin were approved.

Dr. Jardine announced that there was no set order for dealing with the various reports because of the lack of availability of certain of the Chairmen from time to time.

The following is a chronology of the reports in the order they were dealt with at Council.

C.M.A. COUNCIL ON MEMBERSHIP SERVICES – Dr. D.B. O'Brien briefed Council on the operation of the C.M.A. Retirement Savings Plan describing by the use of charts in his report how well it compares from a variety of points of view with other plans, noting that the plan is managed by experts on behalf of the members of C.M.A. and not by doctors. Dr. O'Brien noted that there is increasing involvement by C.M.A. in the field of Retirement Counselling as the Retirement Savings Plan ages and that facilities are expanding to satisfy this requirement. He drew attention to the availability of funds in the form of loans to doctors starting out in practice and suggested that more advantage should be taken of this low cost benefit.

Dr. O'Brien's report noted that membership dues in the provincial medical associations are not income tax deductible items for physicians who are not self-employed, and that C.M.A. has had little success in convincing the Federal Government that it would be fair and reasonable to allow this. His report noted that if an employer's conditions of employment for a doctor includes a requirement for the physician to be a member of the provincial medical society, then the dues would be deductible from one's income tax. The view was expressed that this constituted discrimination against the salaried doctor since no similar requirement exists or will exist for the self-employed physician. The necessity for membership in the Medical Society applied equally well to self-employed and salaried physicians (see Membership Committee Report for further discussion on this subject).

MEMBERSHIP COMMITTEE REPORT – Dr. A.H. Parsons' report noted the steady increase in Society membership from 911 in 1971 to 920 in 1972, this of a total of 1,157 physicians registered in Nova Scotia. In drawing attention to the numbers of non-members, Dr. Parsons' report recommended that the Society negotiate with Dalhousie University and any other employer of physicians in the Province with the aim of obtaining membership in the Medical Society of Nova Scotia as a benefit of employment. Dr. C.B. Stewart felt that the Society is in no position to approach the University with such a proposal until such time as it is required that self-employed physicians must also be members of the Medical Society, which in his view is essential as these non-members be they salaried or self-employed reap the benefits of the Society's work and therefore should be required to contribute to the functioning of the Society. He expressed the opinion that the University would give serious consideration to a proposal that Society membership be a benefit of employment for University physicians if the same criteria applied to self-employed physicians.

Dr. G.G. Simms, Deputy Minister of Public Health, favoured the proposal and informed the meeting that he would be pleased to work with the Society as it seeks to work out a satisfactory solution to the problem. The resolution was carried.

It was noted that medical students attending Dalhousie University are all now members of the Medical Society of Nova Scotia and that three of their members sit as voting members on the Executive Committee of the Society. In addition, five others join these three as members of Council.

FINANCE COMMITTEE REPORT – Dr. D.B. O'Brien presented his report for consideration of Council noting that Montreal Trust Investment Department had been consulted regarding alteration of the Society's Investment Portfolio and that their advice had been to leave the Portfolio as it existed. He noted that although expenses continue to climb steadily the financial picture is quite good and there is no requirement for consideration of a membership dues increase. The Budget for fiscal 1973 was approved.

PUBLIC RELATIONS COMMITTEE REPORT – Dr. K.P. Smith's report was a comprehensive review of the activities of the Public Relations Committee and the Society's Public Relations Consultants during the year of 1972. The report contained no recommendations and was received for information without further discussion.

MEDICAL SOCIETY REPRESENTATIVE TO PROVINCIAL MEDICAL BOARD – Dr. K.P. Smith's report was presented for information, following which he was subjected to lengthy and detailed questioning regarding the activities of the Provincial Medical Board. In response to the question as to why has not the Board taken positive action regarding the Medical Society proposal for an expanded Medical Audit Program in Nova Scotia, Dr. Smith replied that the deferment of action following approval in principle was because the Board wished to see what proposals the Health Council would make relative to the Future Role of the Provincial Medical Board.

Dr. Woodbury criticized both the attitude and performance of the P.M.B., pointing to a number of items in Dr. Smith's report on which action had not been taken. He expressed the opinion that the Board is incapable of any action on its own initiative and deserved censure. Dr. Myrden and Dr. Smith responded noting that this brief report submitted for information did not include the details of positive programs in which the Provincial Medical Board is involved – for example – inspection of intern training programs and facilities.

Wide concern was expressed over the Provincial Medical Board authorization of the straight internship which resulted in certain of the candidates not proceeding with their specialty training but proceeding to general practice, having been licensed following completion of the internship. In response to queries regarding the extent of monitoring, assessment and control of these individuals, Dr. M.R. Macdonald stated there was nothing specific but the very few individuals involved were being monitored very carefully. He noted again that their license had been granted with unwritten condition that they would continue through specialty training and not enter general practice, and that this had not been adhered to; however, the rules have now been changed and any such doctor changing his mind about continuing with specialty training will not be allowed to practice until he has "repaired" his internship. It was confirmed that the straight internship program will be discontinued.

Further discussion of the Society's proposal that the Medical Audit Program be expanded in the Province highlighted the need and necessity for this form of peer review in relation to raising the quality of medical care. It was resolved that the Provincial Medical Board be urged to take immediate action in funding of the proposed Medical Audit Program.

Dr. A.N. Lamplugh introduced the subject of excessive delays in completing legal action against physicians charged with offenses, noting that in certain instances the physician involved has been allowed to practice for many months when evidence indicated that this might not be in the best interests of the public. More positive action by the Board in such cases was suggested. Dr. Macdonald replied that some months ago the Board had requested amendments to the Medical Act which would permit the suspension from practice of a qualified medical practitioner whose conduct is under investigation if it is thought that the interests of the public would be best served and protected by this action. A resolution was passed directing the Society to urge the Government of Nova Scotia to speed usual court proceedings when dealing with medical practitioners' alleged offenses both to protect the public in the interim and give more humane treatment to the physician.

MEDICAL ARCHIVES COMMITTEE REPORT – Dr. R.F. Hand recently appointed Chairman of this Committee reported that although the Committee had been relatively inactive during the year because of the absence of a Chairman, there has been a flurry of activity in recent times that should be of interest to all Society members. It has been determined that the Dean of the Faculty of Medicine is most interested in the subject of Archives and has made available extensive space and facilities for storage, cataloguing, and care of archival material. In addition, the librarian of the Kellogg Health Sciences Library, who is a member of the Joint Committee, is prepared to undertake the co-ordination of activities required to ensure that the history of medicine is properly cared for. Dr. Hand expressed the opinion that many physicians were not making their archival material available to the Committee until there was clear evidence that any items submitted are being safely and properly cared for. A resolution by Dr. Hand to the effect that in view of the allocation of extensive space in the Medical Library the valuable documents, photographs, instruments, and rare books for the care of the Archives Committee of The Medical Society of Nova Scotia, and the necessity of the proper arranging and cataloguing of this material THAT the Society allocate a sum of money sufficient to cover the cost of one medical student for Summer employment was approved. This was subsequently referred to the Executive Committee for determination of the exact money required.

Later in the afternoon, Dr. G.W. Turner, in his address to the Annual Meeting, proposed that the Society acquire a mace, the use of which would reflect the dignity and importance of meetings of General Council of the Medical Society. He also offered to make a substantial contribution to the acquisition of such a symbol. He suggested that it be designed by the Archives Committee and that an appropriate space for engraving the names of the Society Presidents be included in the design. Dr. Hand introduced the following motion which was subsequently passed: "WHEREAS the acquisition for a mace will undoubtedly reflect the dignity and importance of the deliberations of this Medical Society of Nova Scotia BE IT RESOLVED THAT a mace be acquired by the Society, THAT the Archives Committee be made responsible for the design of this mace and submit this for approval by the Medical Society not later than October 1, 1973, and THAT sum of money not to exceed $300. be made available in the fiscal year 1973 for design study." Dr. Hand stated that consideration was given to financing the purchase of the mace and noting that eventually some fund will have to be established. It was felt that this matter should not be included for consideration at this time because it is not possible to estimate the cost. When the design is presented, Dr. Hand said it would include reference to the engraving potential and an estimate of the cost and ways of funding same.

MEDICAL SOCIETY REPRESENTATIVE TO C.M.A. BOARD OF DIRECTORS REPORT – Dr. F.A. Dunsworth noting that his report was brief reminded the meeting that during the past year he had attended all meetings of the C.M.A. Board of Directors and following each reported to the Executive Committee of the Society. He noted that the financial position of the C.M.A. is excellent and that as yet the enlarged economic departments of C.M.A. had not yet placed any financial strain on the organization. The dues increase authorized by 1972 General Council has been deferred and will be considered at next General Council.

Dr. Dunsworth reported that C.M.A. was reviewing in considerable detail the Hastings Committee Report. In response to a

question as to whether or not the recommendations of the Report would be imposed upon the nation in the very near future, Dr. Dunsworth observed that this would not likely be the case but that it would be very carefully reviewed by Governments to check the validity of certain of the recommendations.

C.M.A. COUNCIL ON ECONOMICS REPRESENTATIVE'S REPORT – Dr. G.C. Pace stated that his report was for information only, being disseminated to keep members informed as to the activities of his Council. With reference to continuing business, he reported that his Council was concerned with such items as community health centres, the economics of the Hastings Report, surveillance methodology, structure of fees, physician and patient profiles, and development of the C.M.A. Department of Economics. His report was received for information.

MEDIATION COMMITTEE REPORT – Dr. G.W. Turner reported that the Medical Society continues to receive a fair volume of complaints which concern such subjects as physicians billing above tariff, excessive charges for services rendered, charges for services not covered by M.S.I., solicitation of business by physicians, sale of samples, rudeness on the part of physicians, and refusal to provide services. All these complaints which are received in writing are referred first to the President of the Branch involved in hopes that personal contact between the Branch President, the physician involved and the complainant will result in mediation of the problem. When this is not possible, the President must then become personally involved. He noted too that the incidence of telephone calls to the Society office is fairly high and considerable time is spent discussing problems with complainants who for one reason or another do not wish to place their complaint in writing.

Dr. Turner felt it would be wishful thinking to hope that the volume of complaints against members of the medical profession will decrease. He anticipated that Branch Presidents can expect to become increasingly involved in this process in the years ahead.

DISCIPLINE COMMITTEE REPORT – Dr. G.W. Turner reported that no complaints had been received this year necessitating action by the Society's Discipline Committee.

MATERNAL & PERINATAL HEALTH COMMITTEE REPORT – Dr. D.W. Cudmore reported on Nova Scotia maternal and perinatal mortality. Of particular interest is that for 1970 the perinatal mortality rate fell slightly but at a lesser rate than other provinces, leaving Nova Scotia with the worst record in the country. The neonatal mortality rate fell considerably leaving Nova Scotia with the second lowest rate in this category. Preliminary data for 1971 shows a continuing decrease in perinatal mortality. The greatest decrease in mortality rates took place in Cape Breton leaving Western and Fundy regions the highest mortality regions in the Province at this time.

Dr. Cudmore reported that the Government had reached the decision to fund the perinatal demonstration project designed to further improve obstetric and neonatal care throughout the Province. This project which is more properly known as the Reproductive Care Program has in the past received the support of the Medical Society, Health Council, and Minister.

Dr. Cudmore's recommendations that the Committee continue to function in its current capacity, and that it should continue to co-operate with the development of the Reproductive Care Program for Nova Scotia were approved.

PROVINCIAL LIAISON COMMITTEE ON NURSING – Dr. G.D. Douglas, Medical Society Representative on this Joint Committee of the Hospital Association, Registered Nurses' Association, and Medical Society, gained approval of Council for guidelines for coronary care and intensive care units that his Committee had developed. These guidelines will be incorporated into the new booklet on Medical Nurse Procedures and published in the near future. He referred to problems his Committee will be considering in the future. These include difficulties encountered in certain hospitals regarding patient harassment by increasing teaching loads.

MEDICAL SOCIETY REPRESENTATIVE TO V.O.N. BOARD OF GOVERNORS – Dr. A.G. Cameron reported verbally that he had recently received a copy of a draft Health Council report on a proposed home care program with the request that he undertake on behalf of the Society a review of same. In his opinion, the proposal was quite adequate and he noted with pleasure plans for a pilot program in home care were included.

REPRESENTATIVE TO THE BOARD OF REGISTRATION OF CERTIFIED NURSING ASSISTANTS – Dr. Macadam Duncan reported that the education of the C.N.A. is being taken out of hospitals and directed towards vocational schools. The pilot program at the Dartmouth Vocational School has been approved and others are planned for additional vocational schools with Middleton being next. His report stated that the C.N.A. is fulfilling a useful role in both hospital and nursing homes, and will probably become the backbone of bedside nursing care in the future.

REPRESENTATIVE TO THE MEDICAL ADVISORY BOARD OF THE NOVA SCOTIA TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION – Dr. J.J. Quinlan's report included reference to the developing home care program for patients with chronic obstructive pulmonary disease. It has been demonstrated that in many cases these patients can have most of their problems attended at home. The Association has provided assistance to this program in a variety of ways. The co-operation of the Director of the Fundy Health Unit and the physicians involved is resulting in the development of an effective program.

Noting that the Association is still very much concerned with the problem of tuberculosis control, he emphasized that this problem is still very much with us today. Control of tuberculosis requires constant vigilance by all concerned.

The first session of the Annual Meeting convened at 4:30 p.m. at which time Dr. G.W. Turner delivered his presidential address to members of the Society. His address appears in the December 1, 1972 issue of the Nova Scotia Medical Bulletin.

Following Dr. Turner's address, Dr. J.A. Myrden, President-Elect, spoke on behalf of all members of the Society in thanking Dr. Turner for his thoughtful and provocative observations. In stating that Dr. Turner's performance during the year had been outstanding, he noted too that he had filled the office with dignity and brought considerable credit to the medical profession.

The second session of Council convened at 9:00 a.m. Friday, November 24, 1972 with Dr. P.B. Jardine presiding.

REPORT OF MEDICAL SOCIETY REPRESENTATIVE TO BOARD OF EXAMINERS OF THE NOVA SCOTIA ASSOCIATION OF SOCIAL WORKERS – Dr. E.A. Smith noted that the main function of the Board is to assess social work candidates who have applied for Nova Scotia registration, but who have been trained or have experience in unrecognized training centres in foreign countries. Although no candidates had applied during the past year, he recommended that the Society position on this Board remain active for another year. This was approved.

REPORT OF CANCER COMMITTEE – Dr. R.M. Cunningham's report contained reference to the high incidence of colon and rectum malignancy and recommended most strongly a general change in the diet of our population. He said there is ample to suggest that our diet contains far too much processed foods and that an increase in roughage intake could well cut down on this form of malignancy.

His report complimented the Canadian Cancer Society for their work and approved the general change from danger signals to safe guards. His Committee also suggested a more realistic account of symptoms and disease processes be made available and this should be the on-going work of this Committee. His report also made reference to news media advertising of tonics which appear to restore health, weight loss, and lassitude in the elderly which may well delay their rational approach to the medical practitioner. His Committee approves of an honest approach with less emphasis on the crisis aspects of medicine.

A recommendation of his report that the immunoassay test of bowel malignancy be made available as soon as possible brought forth the comment that this test had been developed on a research basis and as funds are now available will become available on a routine basis.

A second recommendation of his report put the Committee on record as strongly recommending greater availability of hostel accommodation in Halifax for malignant and other diseases. As well, he recommended that the level of poverty accepted by the Canadian Cancer Society for their assistance programs be reviewed upward in view of changes in cost of living since the original criteria was established. These recommendations were approved.

REPORT OF MEDICAL SOCIETY REPRESENTATIVE TO C.M.A. COUNCIL ON MEDICAL EDUCATION – Dr. D.C. Brown introduced his report for information noting that the major topic selected for study by his Council during the past year was continuing medical education, but also included study of undergraduate medical education, licensure and certification, and training of allied health personnel. His report included recommendations passed by C.M.A. General Council in June 1972 as well as by his Council in September 1972.

Dr. C.B. Stewart directed attention to AR523, asking for a definition of limited licensure and what time table had been established for its introduction. Dr. Brown replied that at the moment limitations on licenses are being considered in terms of time only and not type of practice. In due course this facet of limited licensure will be given further study. Dr. Steeves expressed the view that the term 'limited licensure' is a negative one and leaves an entirely wrong impression as to what is being suggested. He proposed that the term be replaced by 'specific licensure'. There was general agreement that this was distinctly more positive and Dr. Brown thanked him for his suggestion.

The subject of straight internship versus rotating internship arose again with it being agreed that if straight internships are continued they should be only available to those entering a specialty and arrangements ensured that if the individual later on did go into general practice his training gaps would have to be filled by some form of rotating internship.

Returning to the subject of time limited licensure concern was expressed that requirements for repetitive examinations by physicians would prevent most doctors from settling down to the practice of medicine and the constant worry over forthcoming exams would have a serious effect. There was general agreement that development of suitable continuing medical education programs would be a far more satisfactory way of keeping physicians updated. Dr. J.H. Quigley said the Halifax Medical Society had discussed this subject and felt that any programs adopted should be positive ones with emphasis on stimulation of doctors' desire to continually improve themselves. Any peer review program in this context must be clearly non-punitive.

There was concern expressed from the floor as to what elements of the Medical Society assisted Dr. Brown as his Council discussed and studied these various complex problems. The comment that this would be the Society's Committee on Medical Education was accepted.

COMMITTEE ON MEDICAL EDUCATION – Dr. J.E. MacDonell reminded Council that it had approved a program of continuing medical education, commonly referred to as the concept of medical audit, and that there had been some progress in implementing these recommendations. He reported that the Division of Continuing Medical Education, in spite of a very limited budget, had made significant progress in introduction of this concept in certain of the general hospitals throughout the Province. He reported that in his hospital his Committee had attempted to further develop the practical techniques in utilizing patient care appraisal techniques. Using view graphs Dr. MacDonell made a brief presentation on how such a program actually works.

Choosing the subject of the management of acute myocardial infarction, he described the steps involved by a typical medical staff, having chosen this particular problem, established criteria in terms of diagnosis, management, treatment and follow-up; prepared performance levels of the physician involved; and conducted critical self-review analysis and reconsideration of basic criteria. Dr. MacDonell stressed that this patient care appraisal program can in no way be misconstrued as an investigation of the performance of any single physician. He noted too that the program in his own hospital has been very well accepted and indeed the participants are finding it an exciting experience.

Dr. Brown expressed his appreciation to Dr. MacDonell and his Committee for the help he had received from them. Dr. Steeves reminded Council that St. Martha's Hospital deserves high praise for their work in developing this program, noting that St. Martha's Hospital is recognized throughout Canada as a leader in development of this program.

Although it was noted that all general hospitals in Nova Scotia have both the facilities and staff available to develop these patient care appraisal programs, it was noted that outside stimulation to each of the hospitals would be required to develop the programs. It was agreed that the Provincial Medical Board, Hospital Insurance Commission, and medical staffs of hospitals, should be encouraged to take advantage of the latent potential for continuing education of physicians. The recommendations contained in Dr. Brown's report were adopted by Council.

AD HOC COMMITTEE FOR CO-ORDINATION OF PEER REVIEW AND PROFESSIONAL SELF-DISCIPLINE – Dr. G.C. Pace informed the meeting that the proposal appearing in the Reports to Council had been replaced by a hand-out circulated to all members during registration. Dr. Pace's report was subjected to some criticism with concern being expressed about the considerable power that would be conferred upon the Peer Review Committee. It was felt the activities of such a Committee would be all encompassing and generally not too acceptable. Dr. Pace noted that his Committee did not consider this a final proposal but was submitted for discussion in order that the Committee could consider the matter and come up with a more acceptable suggestion for consideration by Council. The meeting complimented Dr. Pace on his efforts so far. The subject of development of peer review programs is difficult indeed because of the wide variety of feeling about such a process. In spite of Dr. Pace's comment that the program should be considered one of non-punitive nature, views were expressed that the proposal included suggestions to the contrary. Dr. E.A. Smith expressed the opinion that any program of this nature should most certainly include non-members of the Medical Society, as all physicians should be expected to participate in such a program as this.

The meeting agreed that Dr. Pace's report be received for information only and referred back to his Committee for reconsideration, review by the Branch Societies, the Executive Committee, and then to Council 1973.

PUBLIC HEALTH COMMITTEE REPORT – Dr. A.C. Walkes' report dealt primarily with the Cape Breton Health Planning Project and the subject of Aging. Considering the former, his Committee noted that the most valuable features of the K.P.M. Report were its emphasis on levels of care and need for classification of beds and facilities in terms of patient requirements, emphasis on home care, its emphasis on prevention and community treatment of illness and its considerable accumulation of data on the health needs of the area. On the other hand, his Committee felt the proposed organization was too rigid and authoritarian, and that medical expertise was poorly represented. The need for medical representation on the regional health council as well as community boards was stressed.

With respect to the subject of aging, Dr. Walkes' report noted that existing facilities are inadequate in terms of both quantity and quality and more extensive extended care facilities are required. His

report included the following recommendations which were approved:

1. It is recommended that co-ordinated home care programs be instituted:

(a) to provide health services to selected patients in their homes or licensed residences,

(b) to provide care in an environment familiar to the patient and continuity of care,

(c) to shorten the stay of selected patients or remove the necessity for hospitalization,

(d) to treat patients adequately in their homes at less cost than is possible in hospital.

2. We also recommend that patients be selected for the program by a committee on which there is a doctor, public health nurse, a social worker and that records be kept and reviewed regularly; and that the services provided be comprehensive.

3. We further recommend that the patient must be under the medical supervision of his family physician or a substitute physician if not possible.

4. The Committee recommends that extended care hospitals, nursing homes and home care programs be financed by the Provincial Government.

5. Because so many people are on fixed incomes together with the general apathy that the aged has in preparing meals, it is recommended that a "meal on wheels" program be instituted throughout the whole health system.

6. The Committee also recommends that more specially constructed low rental senior citizens housing should be available.

NOVA SCOTIA REPRESENTATIVE TO C.M.A. COUNCIL ON COMMUNITY HEALTH – Dr. A.C. Walkes reported that his Council is considering a variety of subjects which include nutrition, noting that greater emphasis should be placed on this subject in the teaching process, abortion, chiropractic, veneral disease, population policies, suicide, and aging; as well as the Hastings Report and smoking in relation to good health. His Council has recommended that there be a ban on smoking at all meetings of General Council and that a booth be set up at the Annual Meeting to publicize the health hazards of smoking. His report was received for information.

TRAFFIC CRASH COMMITTEE REPORT – Dr. S.F. Bedwell's report dealt with the subject of emergency care of the sick and injured and their transportation. The basic concept proposed and adopted by Council is that Halifax must not be expected to handle every emergency medical problem for the Province and that controlled decentralization is required. His most comprehensive report dealt with the organizational aspects of this subject as well as medical personnel requirements, transportation requirements, and communication requirements.

His Committee recognized the requirement for training of suitably selected personnel to deal with emergency medical care. Proposed was that the Branch Societies choose two of their members interested in this problem and arrange for them to obtain necessary training and development of skills necessary to carry out their duties. It was recommended that the Faculty of Medicine, Dalhousie, implement undergraduate training in emergency medical care in order to train future peripherally practicing physicians.

With respect to ambulance standards, it was agreed by Council that those set out in Chapter 51 of "Emergency Care and Transportation of the Sick and Injured" be accepted. This particular section also included a number of principles to be adhered to with respect to an ambulance program.

With respect to ambulance personnel, Council agreed that they must be properly selected, properly screened, properly trained, and properly remunerated. Also approved, and this to be communicated to provincial authorities, was an ambulance attendants' training program.

Concluding with comments regarding setting up an adequate two-way communication control organization, Dr. Bedwell's report alluded to the very small cost inherent in the suggested proposals. All the recommendations included in his report were accepted.

Dr. Bedwell's Committee introduced a special resolution reading as follows:

"THAT the Medical Society of Nova Scotia request the Government of Nova Scotia through the Attorney General's Department to amend the Motor Vehicle Act of Nova Scotia to embody the following principles:

THAT every legally qualified medical practitioner shall report to the Minister of Highways through the Registrar of Motor Vehicles and the Medical Advisory Committee on Driver Licensing the name, address and medical condition of any patient 16 years of age or over who in the opinion of the medical practitioner has

(a) A medical condition which makes it dangerous to the patient or to the public for that patient to drive a motor vehicle, and

(b) Continues to drive a motor vehicle after being warned of the danger by the medical practitioner, and

(c) That it is equally encumbent on every patient that they report this condition to the Minister of Highways through the Registrar of Motor Vehicles and the Medical Advisory Committee on Driver Licensing when being told of this hazard by the medical practitioner."

It was noted that both Ontario and British Columbia have similar legislation as proposed in the foregoing resolution. It was confirmed that the term "medical" is used in the very broad concept to include emotionally irresponsible, emotionally unpredictable, the easily angered, the hostile, etc. The feeling was expressed that the legislation arriving out of this resolution will protect physicians who report patients whom he feels are not fit to drive a motor vehicle. The resolution carried.

REPORT OF MEDICAL SOCIETY REPRESENTATIVE TO NOVA SCOTIA HIGHWAY SAFETY COUNCIL – Dr. S.F. Bedwell's recommendation that Branch Societies begin immediately to work with the Nova Scotia Highway Safety Council in setting up local community chapters in order to help instill some sanity and safety into the local operation of vehicles; and into the problems of local drinking drivers; and into the problems faced by the young and inexperienced driver was approved.

REPORT OF THE PRESIDENT OF MARITIME MEDICAL CARE INC. – Dr. A.N. Lamplugh provided Council with a most comprehensive summary of the activities of M.M.C. during the past year. His report included the details of the private side operation with particular reference to the improvement which has taken place in the Pharmacare Program; as well he reviewed the functions of important committees of the corporation and made reference to the special projects undertaken during recent revision of the Medical Society Fee Schedule. He concluded his report with reference to the excellent relationships between M.M.C., the M.C.I.C. and the Medical Society of Nova Scotia.

SPECIAL RESERACH GROUP REPORT – Dr. P.E. Kinsman reported to Council on the activities of the Special Research Group during the past year noting in particular the Medical Society's submission to the Health Council on the subject of The Future of Health Care Programs in Nova Scotia (this was included as an appendix to Dr. Kinsman's report and is available through your Branch President or Secretary for perusal). Council approved his resolution that the Special Research Group cease to function under its previously given terms of reference, as its task has now been completed.

Dr. C.B. Stewart stated that a most important facet of the long-term planning of health needs was being over-looked and given little attention. He therefore moved that in order to obtain accurate data on medical manpower on an annual basis, the Medical Society

requests the Provincial Medical Board, in co-operation with Federal authorities, collect appropriate statistics in association with annual licensure; and that the Society offer to co-operate with the Board in determining the detail of the information required by the Board and the Society. This was approved.

WORKMEN'S COMPENSATION BOARD REPORT – Dr. G.H. Cook reported that he had received no information of difficulties being encountered by physicians in their dealings with W.C.B. He also noted that he had had several informal meetings with the Board Chairman, as well as some of the commissioners. Relations with the W.C.B. continue to be good.

INSURANCE COMMITTEE REPORT – Dr. R.A. Perry reviewed the circumstances which led to the decision to investigate the desirability of improving the Society's Insurance program. This resulted in the adoption of a new group life plan underwritten by Imperial Life Assurance and another group plan with Income Disability and Reinsurance Company to cover Disability, Business Expense and Accidental Death and Dismemberment. The Company of Murray G. Bulger & Associates was retained to administer the plan.

After six months of operation, participation far exceeds that of the previous plan which had been in effect for some 20 years. As an example, previous group life coverage was $8,000,000 while the new plan coverage now exceeds $13,000,000 and continues to grow at a steady pace. The average premium per $1,000 life coverage has been reduced from $6.25 to $5.48.

The plan will improve with time. The next fiscal year should show a return to the Society of at least $4,000 which can be used to improve the plans. Disability coverage has recently been extended from age 65 to age 70.

The report recommended that a new, expanded insurance committee be formed and that the possibility of providing financial counselling be investigated.

ANNUAL MEETING – 2nd SESSION – Dr. G.W. Turner called the 2nd Session of the Annual Meeting to order at noon Friday, November 24, 1972. He then reviewed actions taken by Council in its 1st and 2nd Sessions, Thursday afternoon and Friday morning. These were approved by the members.

Dr. Turner in submitting the report of the Nominating Committee noted that during its meetings, it had come to the attention of the Committee that the members of the Inverness-Victoria Branch had reached the decision that it was no longer practical for the Inverness-Victoria Medical Society to continue in existence and that this decision had been confirmed in writing. Dr. Turner moved that the Inverness-Victoria Medical Society be officially dissolved, THAT the By-Laws of The Medical Society of Nova Scotia be amended accordingly, THAT provision be made for expansion of the boundaries of the Cape Breton Medical Society to include the counties of Inverness and Victoria, THAT on an annual basis arrangements be made for the President and the Executive Secretary, and a representative from Maritime Medical Care Inc. visit and meet with the physicians in the Inverness-Victoria area who are unable to attend regularly the Cape Breton Medical Society meetings by virtue of isolation, to discuss informally Society business. This motion carried.

Appointment of Branch Representatives to the Executive Committee as listed on the inside front cover of the February 1, 1973 issue of the Nova Scotia Medical Bulletin were approved. Alternates approved are as follows: Antigonish-Guysborough – Dr. B.R. Steeves, Cape Breton – Dr. A.M. Khalifa & Dr. G.S. Marsh, Colchester East Hants – Dr. D.G. Dewar, Cumberland – Dr. M.P. Quigley, Dartmouth – Dr. J.W. MacDonald, Halifax – Dr. R.W. Napier, Dr. J.A. Delahunt & Dr. B.L. Reid, Lunenburg Queens – Dr. D. Bruce Keddy, Pictou – Dr. W.A. Hyslop, Valley – Dr. D.F. Craswell, Western – Dr. A.F. weir.

Medical Society Nominating Committee (1973) – Antigonish-Guysborough – Dr. T.W. Gorman, Alt. Dr. R. Sers; Cape Breton – Dr. H.J. Devereux, Alt. Dr. J.A. McPhail; Colchester East Hants – Dr. C.C. Giffin, Alt. Dr. S.G. MacKenzie; Cumberland – Dr. A. Elmik, Alt. Dr. J.P. Donachie; Dartmouth – Dr. C.H. Young, Alt. Dr. Ian M. MacLeod; Halifax – Dr. D.F. Smith, Alt. Dr. J.H. Quigley;Eastern Shore – Dr. R.J. Fraser, Alt. Nil; Lunenburg-Queens – Dr. Wm. W. Bennett, Alt. Dr. G.C. Jollymore; Pictou – Dr. H.A. Locke, Alt. Dr. R.G. Munroe; Shelburne – Dr. J.H.L. Robbins, Alt. Dr. F. Markus; Valley – Dr. H.R. Roby, Alt. Dr. D.L. Davison; Western – Dr. C.R. Wyman, Alt. Dr. A.F.Weir.

The following nominations were approved: President-Elect – Dr. J.A. George, Antigonish; Chairman, Executive Committee – Dr. P.B. Jardine, Musquodoboit Harbour; Vice-Chairman, Executive Committee – Dr. J.F. Hamm, Stellarton; Treasurer – Dr. D.B. O'Brien, Halifax; Honorary Secretary – Dr. T.J. McKeough, Sydney Mines; Finance Committee Chairman – Dr. D.B. O'Brien, Halifax.

REPORT OF LEGISLATION & ETHICS COMMITTEE – Dr. C.H. Graham initiated debate on his report by introducing his Committee recommendation that annual licensing should not be introduced in Nova Scotia. His report included a variety of reasons for his Committee having reached this conclusion. Lengthy debate resulted in the consensus of opinion that the requirement for physicians to pay an annual licensing fee did not actually constitute annual relicensure which had been the original intent when the Medical Act had been rewritten in 1969. In fact any physician may reinstate himself simply by paying up any license fees in arrears. The opinion was also expressed that if the annual payment of a fee allows the Board an easier means of reviewing a particular physician's license, then it follows that any physician who suspected he might lose his license due to unethical practice etc. was not apt to allow his registration fee to fall into arrears. A resolution that this recommendation be referred back to the Executive Committee was defeated. Discussion of the original recommendation continued until noon at which point Council adjourned.

Following lunch, discussion of this report continued with Dr. Graham reporting that at the request of the Executive Committee his Committee had studied proposed amendments to the Medical Act. Specifically, these were:

a. That license to practice should expire at the end of each year automatically and require reinstatement by the Provincial Medical Board to allow the physician to continue to practice.

b. That there should be provision in the Act for holding the Board Members blameless for any injury done to the physicians in their course of duty as Board Members.

c. That it is the duty of every physician to report irregularities of practice immediately to the Provincial Medical Board.

d. That the Medical Act should require for relicensure a registration certificate from a university program, continuing medical education credits recognized by the Royal College of Physicians and Surgeons, continuing medical education credits recognized by the College of Family Physicians of Canada or such other requirements as the Provincial Medical Board might prescribe. Additionally, the Act should set out that if the Provincial Medical Board is not satisfied that adequate continuing medical education has been taken he may be required to demonstrate that he is qualified to practice medicine.

For Information, Mr. Peacocke reported that on May 6, 1972 the Executive Committee had considered these proposals and reached two decisions:

1. that the Society not take further action at this time relative to amendment of the Medical Act with regard to establishment of specific continuing medical education requirements and periodic relicensure, and that the Society endorse in the strongest terms this Province's continuing medical education program; and

2. that the Society not take further action at this time relative to amendment of the Medical Act with regard to the requirement for physicians to report any irregularities of practice to the Provincial Medical Board, but that physicians recognize their

personal responsibility to the public of Nova Scotia in this matter and act appropriately.

Item a. above (annual expiration of license to practice) was withdrawn by the Committee.

The second recommendation regarding provision for holding Board Members blameless for injury done in the course of their duties as Board Members was approved although it was pointed out that this is already provided for in other Provincial Statutes.

Item c. above regarding the duty of physicians to report irregularities of practice was discussed with the result that no further action be taken.

Item d. above regarding requirement for relicensure based on satisfactory completion of specified continuing medical education was defeated, primarily on the basis that C.M.E. programs are not yet adequately developed nor are satisfactory means of measuring competency for practicing physicians available to permit these judgements to be made.

Dr. Graham's Committee recommended that the Age of Consent for any surgical, medical, or dental treatment be established as 16 years, in all provinces and territories of Canada. He noted that this was C.M'A. policy as of last June. This was approved.

The Committee recommendation that the Government of Nova Scotia introduced legislation to the effect "that in any traffic crash where anyone is injured or killed be it mandatory that the driver/s of the vehicle/s involved should have blood alcohol estimations done" was carried.

Dr. Graham's Committee introduced a resolution "THAT the Medical Society of Nova Scotia direct its members that the dispensing of drugs to patients should be considered unprofessional conduct except where drug outlets are not readily available." Although ultimately adopted this resolution was the subject of considerable discussion. The intent of the resolution was that it did not include giving away samples or provision of starter doses on those occasions when a pharmacy would not be open. Appreciating the various special circumstances that would always arise, Dr. Graham stated that the principle of his resolution was that physicians were trained to practice medicine and should leave the dispensing of drugs to appropriately qualified people wherever possible. It was also important that physicians take special care to avoid conflict of interest and accusations of profiteering on drug sales.

It was then moved "THAT the Medical Society declare it to be unethical for any physician to be involved in the provision of primary medical care to patients resident in a rest home or nursing home facility in which the physician has a vested financial interest." Many members spoke to this resolution and with each comment it became clearer that the proposal was most complex and that a decision should not be made at this particular time. It was referred to the Executive Committee for study and report.

DRUG ABUSE COMMITTEE REPORT – Dr. F.A. Dunsworth reported that his Committee firmly believed that all physicians must become more concerned and involved in the drug problem which continues to increase. With respect to physicians whose improper prescribing habits are contributing to drug abuse, he said his Committee feels that it is urgent that the Medical Society take the firmest measures to reduce or eliminate this aspect of the problem. Dr. Dunsworth was congratulated for the excellent work his Committee had done during its brief existence. His recommendation that the Committee's terms of reference be expanded to include the alcohol problem was unanimously approved.

REPORT OF COMMITTEE ON ANAESTHESIA STANDARDS – Dr. S.B. Donigiewicz reported on the provincial survey his Committee had conducted within the past year. Although in Halifax all anaesthesia is done by specialists, this does not pertain throughout the remainder of the Province where the bulk of anaesthesia is done by general practitioners, some of whom are recognized as specialists by the Board. His Committee felt that it was now time to require that physicians entering General Practice demonstrate adequate proficiency in anaesthesia before applying for such privileges in the Province. An amendment to his motion which would have made this mandatory for all physicians in general practice to demonstrate this proficiency was defeated. Dr. Donigiewicz's resolution was passed with the direction that the Society consult with the Provincial Medical Board and Hospital Boards relative to its implementation.

PHARMACY COMMITTEE REPORT – Dr. J.F. Cox reported on his Committee's study of the subject of product selection, use of formularies for bulk purchasing of drugs and the problem of high cost of drugs. His report contained four recommendations which were approved. These were:

1. That required or legislated Drug Substitution or Product Selection or Generic Equivalency be unacceptable other than by individual choice.

2. That in order to ensure correct interpretation of a prescription it should be properly written.

3. That Bulk Purchasing for distribution to Pharmacies of the Province if at all restrictive to good medical practice be unacceptable.

4. That the Medical Society support the concept of a prepaid Pharmacare program.

CHILD HEALTH COMMITTEE REPORT – Dr. A. Prossin reporting for Dr. L. Gursahani stated that the Committee had concerned itself with the problem of measles vaccination, small pox vaccination and the subject of availability of vaccines to physicians for use in their offices at no charge to the physician. He reported that the special committee of the Society and Department of Public Health had recommended to treasury that measles vaccine be made available to physicians in their offices at no charge in order that it could be provided free to their patients in the same manner as those patients attending clinics. Dr. G.G. Simms, Deputy Minister of Public Health, stated that the cost of this would likely be in the order of $40,000 to $50,000 a year and he was not sure that it would be favourable received. It was noted that the existing arrangement was in a sense discriminatory and that for those who could not afford the vaccine there was loss of freedom of choice of a physician, in that they had no choice but to attend a clinic. It was also reported that legislation providing for compulsory small pox vaccination will be repealed at the next sitting. Dr. Prossin also reported that the Joint Society/Department of Public Health Committee has strongly recommended the introduction and use of oral polio vaccine in Nova Scotia. Endorsement of the action was given by Council.

Dr. Prossin introduced a resolution "THAT compulsory immunization against measles and rubella for every child on enrolling in school in Nova Scotia be a concept endorsed by the Society, and that this concept be conveyed to the Joint Medical Society/Department of Public Health Committee for consideration." Concern was expressed that such a policy could be construed as forcing medical treatment on people. In rebuttal it was reported that the General Practice and Paediatric Sections believe that this particular policy is medically necessary and available but the public refused to take advantage of it; therefore, legislation is required. The resolution was carried.

OCCUPATIONAL MEDICINE REPORT – Dr. D.S. Reid reported that his Committee had just reorganized this year and had no specific recommendations to make at this time. He did report that action is being taken to establish a Canadian Council of Occupational Medicine with one of its objectives being generation and maintenance of a high standard in the specialty of Occupational Medicine. He also stated that he had been in communication with the Department of Public Health with respect to involvement in and consideration of mutual problems in occupational medicine. He asked that the Society make public the information that his Committee is available to discuss problems relating to occupational medicine with any interested physicians. Dr. Simms reported that

Government interest in this subject is increasing as new problems arise. He reported that the Government is expanding its facilities to deal with these problems and looks forward to closer association with this particular Committee. He noted that the Government Department expect to have working on this subject an engineer, a physician, and a nurse, and will recognize this Committee as an advisory group to assist this team.

REPORT OF NOVA SCOTIA REPRESENTATIVE TO CANADIAN CANCER SOCIETY – Dr. J.A. Aquino as Society representative to the Canadian Cancer Society reported on certain of its activities. The Welfare Committee of the Society, now known as the Patient Services Committee, is preparing a brief to Government recommending that the qualifying income level of $3,500 be raised to $5,000. Referring to the Colostomy Program he noted the tendency to use a special bag and appliance such as the "Hollister" costs the Cancer Society about $225 per year per patient. Other means are available at considerably lesser cost and considering the volume of 200-300 patients savings could be considerable. He made a plea that consideration be given to use of other appliances where feasible without sacrificing good medical care. He also made reference to the Moral Support Program giving as an example the program of Laryngectomee patients calling on others who may undergo the same procedure. He noted this program may be expanded but it is a very delicate matter and will require proper planning. The Society has concluded that the use of the term "seven dangers" would be better changed to "seven safeguards" and urged that this be recognized and adopted.

Dr. Steeves requested that acknowledgment be given to the Cancer Society for its continuing financial support of the continuing medical education programs.

MEDICAL RELIGIOUS LIAISON COMMITTEE REPORT – Dr. S.M. Woolf reported on behalf of Dr. C.F. Brennan who was unavoidably absent. This report stated that the Canadian Catholic Bishops have approved of female sterilization in Catholic hospitals in Canada with each Diocese being responsible for appointing a Medical-Moral Committee with similar sub-committees in each hospital chosen for such procedures. Local hospital guidelines established by the Bishops are as follows:

1. Three or more Caesarean Sections
2. Multiparity (greater than 6)
3. Renal Disease
4. Heart Disease
5. Mental Disease
6. Varicose Veins
7. RH Problems

The report noted that unfortunately the refusal or approval of the Committee depends on the personality, cultural, religious, and personal moral background of the members, thus resulting in inconsistency of application of the guidelines at local levels. Two recommendations of the report were approved.:

1. All Catholic hospitals should allow tubal ligation under the guidelines of the Canadian Catholic Bishops in order not to overburden a couple of hospitals and inconvenience patients who wish to have such a procedure done in their own hospital.

2. The Society should meet with the Bishops of Nova Scotia in order to iron out the difficulties with the guidelines at the local level.

MEDICAL SOCIETY REPRESENTATIVE TO THE NOVA SCOTIA HEALTH COUNCIL REPORT – Dr. J.F.L. Woodbury reported on the progress the Health Council is making as it proceeds to the point of delivering its special study report to the Minister of Public Health. He noted that one proposal of Council would be establishing a single Health Commission placing hospital, medical and public health services under one authority and that parallel to this would be development of all administrative services in a single Department of Health. As well, regionalization continued under consideration by the Council and various proposals along these lines were being considered. He noted that the soon to be delivered task force report on Paramedical Personnel is expected to have a profound bearing on the delivery of health care in the future. He expected that the Health Council Report would be delivered to the Minister of Public Health by the end of this year.

PRESIDENTS' LIAISON COMMITTEE REPORT – Dr. G.W. Turner's Report to Council was a lengthy summary of the activities of this Committee and the President during the past year undertaken on behalf of the membership. This report is available to all Branch Presidents and Secretaries, as well as all members of Council and should be referred to by those interested in keeping up to date with Society activities. As well, all of the information has been reported from time to time in President's Newsletters.

Dr. Turner referred to the subject of Chiropractic reporting with disappointment the Society's failure to prevent the cult of Chiropractic from becoming legal in Nova Scotia. His report made reference to the Society's inability to comprehend how a Government could allow such an event to occur in the face of its statutory commitment to the protection of the public. As well, the Society had recommended to the Premier that the matter of Chiropractice be a subject for discussion at the next Canadian Health Ministers' Conference.

Dr. Turner refreshed Council's memory on the position he had taken on behalf of the Society when confronted with the request for advice from a physician asked to serve on the Board of Chiropractice, by referring to President's Newsletter number 10. He added that since that time the Minister of Health had asked the Society to submit a list of names from which the Minister would select an appointee to the Chiropractic Board. Dr. Turner said he had informed the Minister that he would seek the opinion of the Medical Society at its Annual Meeting. Dr. Turner sought Council's endorsation of his action.

Many members spoke in favour of Dr. Turner's position. It was suggested that the motion before Council should be positively worded to ensure that the position of the Society is clear and open-minded. It should also reiterate an expression of the responsibilities of the medical profession in matters such as these. Dr. Stewart noted that generally the public is very much unaware as to what a chiropractor can or cannot do and therefore is often confused over the medical profession's position. He proposed that action be taken to clarify this problem for the public. The following resolution was passed:

"WHEREAS the Minister of Health has stated that 'the Medical Society has (and often by itself) pursued and helped achieve the highest possible standard of medical care for the people of Nova Scotia' and 'has never failed or flinched from its responsibility to criticize where in its view criticism was called for' and 'has never failed to pioneer where pioneering need be done' and 'has never failed to advise when advice was sought' and 'has never failed to zealously accept its role when invited by government to participate in the regulating of the health delivery system.

"AND WHEREAS the Medical Society still accepts its responsibility to provide and maintain the highest standards of health care possible for the people of Nova Scotia.

"AND WHEREAS the Medical Society is similarly committed to the protection of the health of the people of Nova Scotia.

"BE IT RESOLVED THAT the Medical Society strongly support all innovations and improvements in the health field which have sound basis in science and relevant technology, but similarly BE IT RESOLVED THAT the Medical Society not support or appear to support in any way those so-called services which may or may not be legislated into fact which have no sound basis in science or relevant medical technology and which present hazard to the health of the people of Nova Scotia."

The subject of payment for pap smears arose with reference being made to Dr. Turner's report that in September the Executive

Committee had established a select Committee to conduct a detailed analysis of the situation and report to Council and that he had hoped to report on this Committee's activities at this Council. Dr. Turner stated that the Society had not yet received a report but when it was received it would be considered by the Executive Committee and prompt action taken. A number of members expressed surprise regarding this matter and asked that the Committee membership be identified. Dr. Turner said the Committee included representatives from the Sections of Obstetrics & Gynecology, and General Practice, the Committee on Maternal & Perinatal Health, the Cancer Committee, the Uterine Cancer Detection Centre, the Society's representative to the Canadian Cancer Society, the Department of Preventive Medicine of Dalhousie University, and the Family Practice Teaching Unit of Dalhousie University.

Although Dr. Turner's report stated that Dr. H.C. Still is a member of the Joint Medical Assessment Committee of the M.C.I.C. and N.S.H.I.C., it was pointed out that this appears not to be the case. Council directed that this be investigated and rectified immediately.

REPORT OF CHAIRMAN OF THE EXECUTIVE COMMITTEE – Dr. P.B. Jardine relinquished the chair to Dr. P.D. Jackson, Vice-Chairman of the Executive Committee, in order to present his report to Council.

Dr. Jardine expressed the hope that more and more Society members would become involved in Society business. Their help and advice is essential as the Medical Society seeks achievement of its goals. He extended special thanks to the retiring members of the Executive Committee, these being Dr. J.F.L. Woodbury, Dr. P.D. Jackson, Dr. W.F. Mason, Dr. P.S. Gardner, Dr. D.M. Andrews, Dr. W.E. Pollett, and Dr. J.C. Aucoin.

Dr. Jardine's report represented a detailed resume of the activities of the Executive Committee during the past year and the purpose of his report was to gain approval of the actions of the Executive Committee on behalf of the membership during the past year, the bulk of which had been reported to the membership through the President's Newsletters. As well, Reports to Council which had been considered up to this particular point included reference to the bulk of these business items. The Executive Committee report was approved by Council.

ANNUAL REPORT OF NOVA SCOTIA CHAPTER OF CANADIAN ACADEMY OF SPORTS MEDICINE – Dr. M.R. Banks informed Council that the Academy (CASM) is a young organization of physicians from all medical disciplines who have an interest in treatment of injuries to athletes. Its aims are twofold; namely, to assist individual physicians in developing their knowledge in this subject, and secondly to assist athletes by educating them in methods of prevention of injuries and rapid assessment and treatment of sports injuries by on-the-spot attendance. Dr. Banks had no specific recommendations to make but pointed out that he would appreciate inquiries and expression of interest by Society members.

ANNUAL REPORT OF NUTRITION COMMITTEE – Dr. C.N. Williams' Committee is planning an educational program for the coming year on the subject of nutrition, this to be available to members through the Bulletin. Planned articles include "Dietary Management of Coronary Artery Disease", "The 'Best' Diet in the First Six Months of Life", "Diet and Diverticular Disease", and "Duodenal Ulcers – Has Diet Any Specific Role?".

His request for funds was referred to the Executive Committee for decision.

REHABILITATION COMMITTEE REPORT – Dr. J.A. Myrden, reporting on behalf of Dr. B.J.S. Grogono, stated that rehabilitation facilities in Nova Scotia continue to lag behind the rest of Canada and that plans to replace the outdated Rehabilitation Centre continue to be discussed without any action taking place. Hope is held that the Health Council Report to the Minister of Public Health will make strong recommendations to improve facilities. In spite of these shortcomings the Committee reported that programs are continuing for amputees, those with spinal injuries and other severe physical handicaps, and as well there is a program for selected cardiac patients.

The Committee recommended a variety of problem areas which should be given consideration. Their recommendation deploring the lack of facilities and lack of action by the Nova Scotia Government in providing a new rehabilitation complex and urging the Government to take prompt action to provide satisfactory comprehensive facilities for rehabilitation which facilities would be worthy of the Province was approved by Council.

MENTAL HEALTH COMMITTEE REPORT – Dr. J.A. Myrden presented this report on behalf of Dr. B.K. Doane. A motion that the standing Committee on Mental Health of the Medical Society of Nova Scotia be disbanded and that in future its aims and activities be taken over by the Section for Psychiatry of the Medical Society of Nova Scotia was adopted. In agreeing to such a proposal, Council felt that it should be compulsory for Sections to report annually in order to keep members informed about Section activities.

Dr. R.O. Jones brought to the attention of the meeting that a Municipal Jail was scheduled to be built in the proximity of the Waterville Hospital and expressed the opinion that this was most regrettable. In agreeing, Dr. Simms stated that this had only just come to his attention. Council passed the following resolution: "THAT this Society is greatly concerned by the proposed location of the new Municipal Jail in close apposition to the Kings County Municipal Hospital. In our opinion this perpetrates the stigma of mental illness which has been a significant block to proper treatment through the years. I therefore move that this Society strongly express its disapproval of this place and urge reconsideration. Resolution to go to the Attorney General, the Minister of Health, Canadian Public Health Association, Canadian Mental Health Association, and the Warden of the Municipality of Kings County."

EDITORIAL BOARD REPORT – Dr. A.J. Buhr's report was presented by Dr. J.A. Myrden. The opinion was expressed that over the past year the Bulletin presented an outstanding example of medical journalism and was a tribute to the people involved in its production. Dr. Buhr's recommendation that the Council of the Medical Society of Nova Scotia endorse the present format of the Bulletin was adopted with enthusiasm.

RH COMMITTEE REPORT – Dr. R.S. Grant's report was presented by Dr. J.A. Myrden. This report was a comprehansive review of the three-phase programme of this Committee in service, prevention and education. Dr. Grant noted that during the year 34 Rh negative pregnancy cases were referred to this Committee by Nova Scotia physicians for specific advice on management. Of the 34 cases 28 infants are living, there were 5 stillbirths and 1 neonatal death giving a survival rate of 82%. He noted that although physicians known to have Rh negative pregnancy cases have been offered the help of the Committee, not all cases have been referred.

Dr. Grant reported that in 1971 there were 1,412 injections of Rh Immune Serum Globulin given to new mothers not yet sensitized to the Rh factor. This program began in June 1968 and from then to June 1972, 4,851 future babies have been protected from Rh Hemolytic Disease. Complete protection of Rh Negative cases has not been attained as yet and efforts will be made to correct this. The Rh Immune Serum Globulin is available for cases of abortions and ectopic pregnancies. Therefore, blood testing should be done at the patient's first visit to her physician because of early termination of these pregnancies.

Council approved three recommendations of this Committee:

1. That the Society endorse the principles and practices of this Committee;

2. That physicians endorse the practice of having Rh testing done on pregnancy cases at their *first* prenatal visit; and

3. That physicians recognize Rh Hemolytic Disease as high risk and consult with the Committee for assistance in management.

PATHOLOGY COMMITTEE REPORT – Dr. J.A. Myrden reported on behalf of Dr. J.H. Cooper, Chairman, Section for Pathology. His report noted that of the 38 pathologists in Nova Scotia, 36 are members of the Section and Society. He noted too that the Executive Committee functioning as a Standards Committee has established liaison with the Hospital Association, Laboratory Directors, Hospital Insurance Commission and the Pathology Institute to promote the ongoing provincial quality control program of laboratory procedures. Dr. Cooper's report also included reference to other activities of the Section including those of its medical/legal Committee as well as action taken in the co-ordination of technician training.

ANNUAL REPORT OF SOCIETY MEMBERS OF THE MEDICAL ADVISORY COMMITTEE ON DRIVER LICENSING – Drs. P.L. Landrigan and C.J. MacDonald reported that the most common areas of discussion within their Committee were mainly to do with visual acuity, uncontrolled diabetes mellitus, epilepsy, cardiovascular complications and psychiatric emotionally unstable people but that the most frequent problem appears to be that of the chronic alcoholic. Reported on was their attendance at Highway Safety Council meeting where study reports on traffic crash surveys were considered. This report contained two recommendations which were approved by Council:

1. In order that meaningful statistics could be obtained locally in view of the fact that most of the major crashes in at least the Halifax-Dartmouth area come to one emergency center that a study of the incidence of crash victims under the influence of alcohol and other drugs be undertaken to establish just how big a factor this is in our crashes on the highways locally.

2. An effort to have the public be more aware of the difficulties which deficiencies in health can have on highway crashes that some larger coverage of an educational program than we presently have should be embarked upon. This could be somewhat of the nature of a television special as has been put on to stimulate the prevention of smoking.

NEW BUSINESS

Pharmacy Ownership – It was moved by Dr. D.R. MacInnes, seconded by Dr. G.H. Cook THAT it be considered unethical for any practicing physician to have a vested interest in ownership or management in any pharmacy within 20 miles of his normal place of practice.

During discussion it came to light that the implications of such a policy were serious and would have unknown effects on many physicians. It was the consensus of the meeting that this required very careful study and in fact a detailed survey should be conducted to ascertain the extent of the problem. It was moved by Dr. D.B. O'Brien, seconded by Dr. J.A. Myrden THAT the foregoing resolution considered at Council be referred to the Legislation & Ethics Committee for study and report. This motion was carried.

Pap Smeras – It was moved by Dr. D.C. Brown, seconded by Dr. R.M. Cunningham THAT whereas the performing of routine Pap Smears is one of the best financial bargains in the practice of medicine, because it has a cost benefit ratio of 1:7 BE IT RESOLVED THAT this Council go on record as recommending that the fee for Pap Smeras be paid according to the following: a) Office visit for the test alone without any other diagnosis or treatment involved; b) In conjunction with an office visit for non-obstetrical or non-gynecological procedure. Nevertheless the Society feels we should reduce the total cost of the Pap Smear program. It is generally recognized after a number of tests have been done and reported as Class I, it is possible to reduce the frequency of Pap Smears, without increased risk to the patient.

In presenting this motion Dr. Brown appreciated that the select committee of which he was a member was submitting a report to the Society but he felt that the immense value of this test program required immediate action on the part of the Society. His actions were therefore directed to this end and not an attempt to pre-empt the committee report. He agreed to the referral motion by Dr. M.A. Smith, seconded by Dr. J.A. McPhail which was carried, on the basis that it would not be delayed for a further year.

MEDICAL PROCEDURES IN HOSPITALS – Concern was expressed that in certain hospitals procedures were being permitted when for a variety of reasons this should not be the case. The opinion was expressed that Boards of the smaller hospitals would benefit by and would appreciate, from time to time, advice in this matter. It was moved by Dr. J.F.L. Woodbury, seconded by Dr. L.C. Steeves THAT since hospital Boards face decisions concerning the safety of their patients under the care of medical staff members and therefore, in consultation with their medical staffs, must decide the areas of medical practice in which an individual doctor may perform with less than specialist training in the area, the Society notify all hospitals that it is prepared to be consulted by them and to assist in providing solutions to such problems. This motion was carried.

Membership Dues – The view was expressed that with the increasing involvement of the Medical Society in a wide variety of programs including education and the political development of the provincial health programs, costs to the Society were increasing. Also increasing are the benefits of this activity to all members of the medical profession, including non-members of the Medical Society. A proposal suggested was that the Rand Formula be applied – i.e. if one reaps the benefits arising out of the actions of an association he may or may not join the association but in any case he must contribute to the cost of operation of the association.

It was moved that membership in the Medical Society of Nova Scotia continue to be voluntary but that the membership dues be collected by the Provincial Medical Board as part of an annual licensing fee from all physicians practicing in Nova Scotia. This motion was defeated; basically, because of the desire of Society members to remain clear and free from the Provincial Medical Board or any other Government control.

It was suggested that the Medical Society and the Provincial Medical Board should co-operate to a greater extent in both consideration and development of medically related programs. Following discussion a motion was approved THAT the Presidents' Liaison Committee explore with the Provincial Medical Board the financing of programs of common concern to the Medical Society of Nova Scotia and the Provincial Medical Board.

Certification in Family Medicine – It was moved by Dr. Macadam Duncan and seconded by Dr. J.A. Smith THAT this meeting endorse the policy of the C.M.A., namely to urge the Federation of Provincial Licensing Authorities to recognize certification in Family Medicine by the College of Family Physicians of Canada by listing the holders of the Certificate in Family Medicine as such as their Provincial Registrar. This motion was carried.

Physicians' Rights – Pointing to the proposed amendments to the Medical Act, Dr. D.R.S. Howell observed that the Board and the Society were going to great lengths to establish in considerable detail and with clarity the rights of the Provincial Medical Board. He felt that this was occurring to the detriment of physician and that their rights were receiving inadequate consideration. He moved a motion seconded by Dr. F.A. Dunsworth that the Medical Society of Nova Scotia recommend that the right of the individual physician be delineated within the substance of the Medical Act of Nova Scotia with the same detail devoted to spelling out the rights of the Provincial Medical Board. This motion carried. It was brought to the attention of Council that in certain instances Government bodies required its members to take an oath of secrecy. It was felt that this was most inappropriate as the business being conducted was that of the residents of Nova Scotia. It was recognized there was a requirement for considerable discretion in many instances; however, this should not require an all encompassing blanket restriction. It was moved by Dr. W.F. Mason, seconded by Dr. J.A. Smith THAT the Medical Society of Nova Scotia urge the Government Paying Agencies to discontinue the policy of an oath of secrecy required by

the Society's representatives on certain committees, wherever this is possible. This motion was carried.

Cape Breton Health Planning Project Report – Dr. Albert Prossin provided Council with a brief but most comprehensive report on the progress of the Cape Breton Health Planning Project. He described the manner in which physicians in Cape Breton had contributed to the original study and are now participating in working out the detail of the concept of the Cape Breton health region. He stressed the importance of physician involvement in all aspects of planning and operation of such a set up. Council found Dr. Prossin's briefing interesting and most informative.

At this point the final Session of Council adjourned and Dr. G.W. Turner called the 3rd Session of the Annual Meeting to order. He presented to the members a resume of actions taken by Council during the 3rd and 4th Sessions of Council. These were endorsed by the membership.

Two Halifax groups (Halifax Interaction which operates a drug crisis and medical aid service for youth at the Victoria General Hospital and Needleworks Community Drug Centre, a drug crisis intervention group operating independently in West Halifax), directly involved in drug abuse prevention, control, and treatment referral received permission to present information indicating the extent to which physicians may be contributing to the drug abuse problem rather than alleviating it.

The Halifax Interaction report noted that physicians are liable to be compromised by the generally manipulative and intelligent drug abuser who knows his way around in the medical field and who by simulating the appropriate symptoms can acquire a number of prescriptions for a given compound from a number of doctors almost simultaneously. The Halifax Interaction representative stated that a few physicians may also be consciously involved in injudicious prescribing practices. Specific anonymous cases were given as examples of injudicious prescribing habits. The representative noted that these details complete with names had been presented to the Provincial Medical Board for action.

The Needleworks report was essentially the same but slightly more radical. It proposed that a 50 percent tax be placed on mood modifying drugs at the manufacturing level, prescribing level, and retail level to provide funds to operate drug rehabilitation and research centres. Their report stressed the lack of education of all people involved in this particular problem. Both groups expressed the opinion that nearly all physicians are sincere in their efforts to heal and alleviate suffering, and that the use of various drugs subject to abuse has a definite validity in a truly medical context. They requested urgent action be taken relative to those physicians who wittingly or unwittingly were contributing to the problem of drug abuse.

The briefing referred to above was well received by the membership and prompt action by the Society was urged through the motion of Dr. J.A. Smith, seconded by Dr. D.R.S. Howell THAT the recommendations and report be referred to the 1st Executive Committee Meeting for early action. The hope was expressed that communication of the problem to all members be given high priority.

The 119th Annual Meeting of the Medical Society of Nova Scotia adjourned at 1:40 p.m., November 25, 1972. □

ANNUAL MEETING EXHIBITS

The Medical Society of Nova Scotia wishes to express its sincere appreciation to those firms which exhibited at our Annual Meeting in November 1972 at the Hotel Nova Scotian.

LIST OF EXHIBITORS

Arlington Laboratories
Burroughs Wellcome
Boehringer Ingelheim Products
Calmic Limited
Cow & Gate Ltd.
Cyanamid of Canada Ltd.
Eli Lilly & Co., Ltd.
Elliott/Marion Company, Ltd.
Encyclopaedia Britannica
Fisons (Canada) Limited
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M.M.C. Inc.
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Ortho Pharmaecuticals Ltd.
Parke, Davis & Co., Ltd.
Pennwalt of Canada Ltd.
Pfizer Pharmaceutical Division
Poulenc Limited
A.H. Robins Co. of Canada Ltd.
Rougier Inc.
Royal Trust Company
The Upjohn Company of Canada
Warner-Chilcott Laboratories
Welcker & Company
Winley Morris Company, Ltd.
Winthrop Laboratories

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

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

D.D.P.

INSURANCE PROGRAM

SOCIETY MEMBERS

EMPLOYEES OF SOCIETY MEMBERS

THE MEDICAL SOCIETY OF NOVA SCOTIA

THE NOVA SCOTIA DIVISION
OF
CANADIAN MEDICAL ASSOCIATION

For information on how your Society's insurance plans may be of benefit to you and your employees . . .

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Life Insurance

Level Term Protection is available in units of $25,000.00 from a minimum of $25,000.00 to a maximum of $125,000.00. Upon attainment of age 66 the protection reduces by 10% of the face amount each year and terminates at age 75.

Age Limit. Any member of the Medical Society may apply, providing the member has not attained age 74.

Waiver of Premiums. If an insured member becomes totally disabled for six consecutive months before age 60, coverage will remain in force for the complete duration of disability without further payment of premiums.

Conversion Privileges. All or part of the term protection may be converted to any of the company's whole life or endowment plans without further evidence of insurability.

Complete Protection. Benefits are payable in the event of loss of life from any cause, even from suicide after two years, anywhere in the world, and in addition to any other insurance carried.

Beneficiary. You may designate anyone as your beneficiary and may change your appointment any time, subject to the provisions of the law.

Ownership. The owner may be yourself or a third party, such as your spouse. However, you are always the life insured. If desired, the policy may be assigned.

Annual Rates per each $25,000.00

Age Last Birthday as at October 1st	*Rate*
Under 31	$ 60.25
31 - 35	70.75
36 - 40	76.50
41 - 45	98.00
46 - 50	127.00
51 - 55	199.50
56 - 60	272.00
61 - 75	422.00

Accidental Death And Dismemberment

Accidental Principle Sum. Benefits are available from $10,000.00 to $100,000.00 in units of $10,000.00

These Accident Benefits are Payable

100% of principle sum
loss of life
loss of both hands, feet, and sight of eyes
loss of one hand and one foot
loss of one hand and sight of one eye
loss of one foot and sight of one eye

75% of principle sum
loss of one arm or leg

50% of principle sum
loss of one hand, foot, or sight of one eye

25% of principle sum
loss of thumb and index finger from same hand

Worldwide 24 Hour Accident Protection including while flying as a passenger in any certified aircraft.

Annual Rate. $9.60 per each $10,000.00 of principle sum.

Income Replacement

Long-Term Disability Protection. Pays to age 65 or for life if disability is caused through injury.

Age Limit. Any member of the Medical Society of Nova Scotia may apply up to the attained age of 64.

Benefit Limits. You may select the Base Monthly Benefit of $500.00 plus additional $100.00 units up to a maximum of $1,500.00 per month. Since benefits are not taxable, the amount selected should not exceed two thirds of regular gross income.

Elimination Periods. You may select the elimination period which best suits your needs – 15, 30, 60, 90, or 180 days. Benefits payments begin after you have been disabled for the period selected.

Liberal Total Disability Wording. Unlike many individual plans, your Society defines "Total Disability" as the "inability to perform the duties of your own occupation" for the first five years of such disability. After the first five years, "Total Disability" means "the inability to perform the duties of any occupation for which you are reasonably fitted by education, training, or experience".

Waiver of Premiums. Premiums falling due after ninety days of continuous disability are waived for the entire duration of such disability.

Annual Rates per Each $100.00 of Monthly Benefit

Age Last Birthday	*Elimination Period in Days*				
as at October 1st	*15*	*30*	*60*	*90*	*180*
Under 31	22.44	18.72	17.40	16.08	14.28
31 - 35	23.88	20.04	18.60	17.16	15.24
36 - 40	28.08	23.54	21.84	20.16	17.76
41 - 45	35.52	29.76	27.60	25.32	22.56
46 - 50	43.08	36.00	33.36	30.72	27.24
51 - 55	50.88	42.60	39.48	36.36	32.16
56 - 60	60.00	50.16	46.44	42.72	37.80
60 - 65	69.84	58.32	54.00	49.68	43.92

Business Expense Protection

Purpose of This Plan is to compensate for continuing expenses in connection with your practise during any period of disability, during which period the normal revenue which pays the expenses is interrupted.

Liberal Claim Certification. It is not necessary to itemize expenses, provide financial statements or proof of expenses at the time of claim. The full benefit is payable for the duration of disability to a maximum of eighteen months.

Income Tax Position. All premiums paid for this benefit may be written off against taxable income as a business expense. Benefits paid under the plan are taken into income for tax purposes.

Benefit Period. Payments begin on the fifteenth day of disability. You may choose a benefit period of twelve or eighteen months.

Age Limit. Any member of the Medical Society of Nova Scotia may apply, who has not attained the age of 69,

Annual Rates per each $100.00 of monthly benefit

Age Last Birthday	*Benefit Period*	
as at October 1st	*12 months*	*18 months*
Under 50	18.00	20.00
51 - 60	27.00	30.00
61 - 70	36.00	40.00

General Information

Eligibility for All Plans. All members and employees of members of the Medical Society of Nova Scotia may apply subject to the attainment of age limits listed above, under each plan. This includes members in research, teaching, administration, intern and post-graduate training. Coverage will be maintained so long as the Master Group Policy is in force and membership in the Medical Society of Nova Scotia is maintained.

Portability. So long as membership is maintained in the Medical Society of Nova Scotia, and you are engaged in work related to medicine, coverage may be carried in any Province or Territory of Canada, and to any foreign country subject to the approval of the Society and the Insurance Company.

For those who Participate in the Plans Previously Sponsored by the Society

Coverage may be transferred to the Society's New Plans without evidence of insurability, providing application is made within thirty days of the expiry of the former plans, which contain the normal statuatory thirty-day grace period. Providing this step is taken, transfer precluding loss of coverage is guaranteed. A reduction in premium rates will apply in most cases and no member will be obliged to pay a higher premium.

Society Owned Profits. The New Plans are designed to vest the profit realized through favourable claims experience with the Society. This surplus may be used at the Society's discretion to further improve the insurance plans, broaden Underwriting Acceptance Standards to permit more members in the plans who would normally not be eligible for reasons of health, or reduce future premium rates.

Guaranteed Issue of Coverage. As soon as 50% of eligible members have applied for coverage in the plans, a minimum amount of $25,000.00 term insurance, and $300.00 per month disability insurance will be issued to all eligible members who have applied or wish to apply regardless of health.

Your support of the Society's Group Insurance Program, evidenced by application for one or more of these plans will contribute to the achievement of the Society's goals more quickly.

If you wish to apply for coverage; increase your present limits; or obtain further information, your inquiries may be directed to:

The Medical Society of Nova Scotia
Group Insurance Program
c/o Murray G. Bulger and Associates Limited
Consulting Actuaries
6009 Quinpool Road, Suite 708
Halifax, Nova Scotia
Telephone: Area Code 902 – 425-3741.

Plans are underwritten by:
Term Life: Imperial Life Assurance Company of Canada
Disability: Income Disability and Reinsurance Company of Canada

Patient, Bed and Bathroom

A STUDY OF FALLS OCCURRING IN A GENERAL HOSPITAL

N. V. B. Manjam,* M.B., B.S.
and
H. H. MacKinnon, M.D., F.R.C.P.(C)
Fredericton, N.B.

Abstract

The pattern of falls occurring in a general hospital was studied, and the predisposing factors were analysed. 143 falls were reported, involving 130 patients.

Falls occurred more commonly in males, especially those in the 61-80 age group, than in females. Ward patients had more accidents than private or semi-private patients. The incidence of falls was approximately 10 in every 1,000 admissions, a rate of 1%.

More than half of those who fell, did so within the first week of admission, and most commonly between the hours of 10:00 p.m. to 6:00 a.m. The urge to use the bathroom was the main reason given by patients for attempting to get out of bed. Falls were more common in patients who had received hypnotics, and most common during the second and third hours following medication. The degree of injury resulting from the fall ranged from none in 60% to severe in 3% of patients.

Accidents occur everywhere: in the home, in schools, in industry or on the highway, and the hospital environment is no exception. Hospital patients are supposed to be protected against accidents, since they are physically or mentally sick, and accidents are therefore potentially more dangerous. The environment is strange, the hospital bed is higher than the domestic bed, and furniture and people around are unfamiliar.

Falls are the commonest hospital accident: Petrovisky, in a nine-year study of 959 hospital accidents, found 809 (84.36%) were due to falls. He quotes a similar incidence of 72%, found by Williams, in a series of 82 accidents.

Material and Method

The accident report forms of the Victoria Public Hospital, Fredericton, New Brunswick, a 318-bed general hospital, were used for the study. The forms gave name, age, sex, type of accommodation, primary diagnosis, the general condition of the patient and a description of the accident. They also contained a note of safety measures used, a statement from the patient, diagnosis of the injury, X-ray reports, if any, and the treatment ordered. Further details were obtained from the patient's chart.

A fall was defined as a loss of equilibrium resulting in the patient meeting the floor unsupported by his legs, with or without injury.

*Department of Neurology, The Medical College of Wisconsin, Milwaukee, Wisconsin 53226.

Relation of age and sex to total incidence

Falls occurring in the immediate environment of the patient during a 16 month period from January 1970 to April 1971 numbered 143 and involved 130 patients. During the same period, there were 13,075 admissions, excluding newborn, giving an approximate incidence of 10 falls per 1,000 patients, or 1%.

The incidence of falls is shown by age and sex in Figure 1. Males fell more often than females in every age group except the 21-40 age group, where there were four males and eight females. Combining all age groups, there were 78 males (60%) and 52 females (40%) who fell, a ratio of 3:2.

Parrish and Weil found that male patients have more than twice as many accidents as do female patients. Sowder found that the male succumbs more frequently to disease and accidents: he uses the term "the fragile male". However, Barsam and Ganam found the incidence of accidents in both sexes to be almost similar. In their series from a chronic disease hospital, there were 243 accidents to 991 male admissions (24.5%) compared to 222 accidents to 966 female admissions (22.3%).

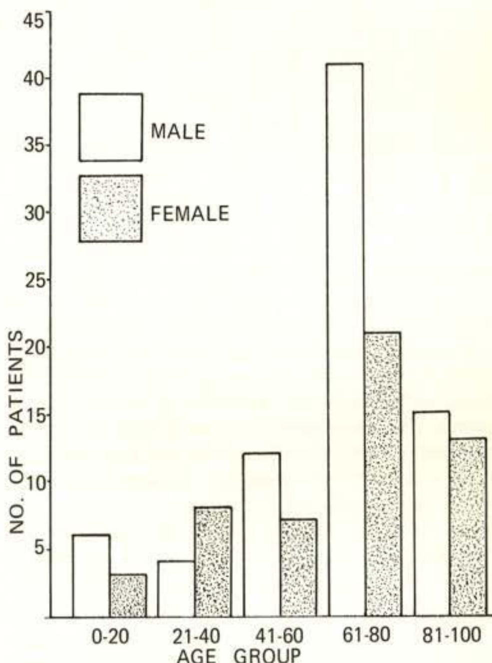

FIGURE 1

Effect of type of accommodation and length of stay

In this series, the highest number of falls occurred in the ward, where 67 (52%) fell, compared to 35 (27%) in the semi-private ward and 21 (16%) in the private ward. Patients fell in the labour room, emergency room and even in the intensive and coronary care units, and these maximum care areas accounted for 7 patients or 5% of all falls. Parrish and Weil also found a higher incidence of falls on the wards as compared to private and semi-private accommodation and attributed this to the "Hi-low" beds and side rails in private areas as compared to conventional iron rod beds in the wards.

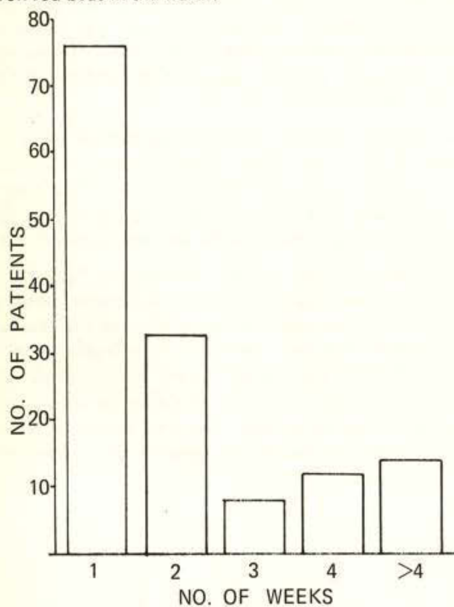

FIGURE 2

The relationship between the incidence of falls and the length of hospital stay is shown in Figure 2. Seventy-six (55%) of 143 falls occurred in the first week, 33 or 23% during the second week and 8 or 6% in the third week. The incidence rose to 12 (8%) in the fourth week and 14 or 10% in those who stayed longer than four weeks. The higher the incidence of falls in the first week could be due to unfamiliarity with the new environment: some patients fell as soon as they entered the ward! The minimum number of accidents in the third week suggests that it takes long for patients to adjust to the environment, but the rise in incidence after three weeks is more difficult to explain. Barsam and Ganam found the average length of hospitalisation in a chronic disease hospital for patients sustaining accidents was nearly three times that of non-accident patients. Thus, the length of hospitalisation appears to be a determinant of accident causation, since the incidence is highest at the extremes of stay.

Effect of restraints

Table I shows the position of the bed railings, and indicates that many patients fall despite restraints or railings. One patient managed to untie a posey belt and climb over the railings. Even when the need for railings is indicated by the doctor, there is a tendency to put up only the top railing. This happened with 18 of our patients, and perhaps encourages the patient to attempt to get out of bed while increasing the chances of his falling. Ludlam has made similar observations, finding that 71% of all patients who go "over the rails", do so between 11:00 p.m. and 7:00 a.m., while only 10% do so between 7:00 a.m. and 3:00 p.m., compared to 19% from 3:00 p.m. to 11:00 p.m. Eighty-six percent of these patients were over 50 years of age, and only 5% were children.

Position of bed railings

Table I

Position of Bed Railings	No. of Cases	%
All of four up	11	8
Two of the four up	18	13
Three of the four up	3	
One of the four up	2	
Patient climbed over railings	4	
All railings up and Posey belt on	1	9
Only Posey belt on	2	
Patient refused to have the railings up	1	
All the railings down	38	26
No information available	63	44
TOTAL	143	100

Using a similar division of the day into "sleeping hours" (2201-0600), "care hours" (0601-1400) and "visiting and relaxing hours" (1401-2200), we found a slightly different pattern of falls. The major incidence still occurred during sleeping hours, accounting for 58 or 41%, but there was a higher incidence during care hours as compared to visiting and relaxing hours: 45 or 31% as compared to 28 or 20% (Table II).

Time of Fall

Table II

Time in Hours	Number of Cases	%
2201-0600 "Sleeping hours"	58	41
0601-1400 "Care" hours	45	31
1401-2200 "Visiting and relaxing"	28	20
Not recorded	12	8
	143	100

Effect of medications

Hypnotics, antihistamines, tranquilizers and sedatives are known to alter the alertness of the patient: 49 of our patients, or 32%, received some sort of hypnotic, 32 (25%) were given tranquilizers or sedatives and five took antihistamines close to the time of a fall. One patient who fell was taking insulin. Twenty-six patients fell within eight hours of medication, and 14 of these fell during the second or third hour after medication, a time when drug action is at its peak.

Other contributory factors

At the time of the fall, 14 of our patients were noted to be confused, eight were drowsy, two were dizzy and one was unconscious. Fasting promotes dizziness and was noted in four patients.

Disease states may contribute to loss of balance or syncope: of our 130 patients, 20 had malignant disease, 14 had atherosclerotic heart disease, eight a cerebrovascular accident and seven diabetes mellitus. Epilepsy was seen in three, depression in three, muscular dystrophy in one and ataxia in one. Malignancy and ASHD are commonest in the age groups most frequently affected by falls.

Electrocardiagrams were abnormal in 46 patients, of whom 21 showed tachycardia, atrioventricular block in seven, atrial fibrillation in six, right bundle branch block in six and left bundle branch in five.

Hypertension was present in 8% of patients who fell, and 14% had a prior rise in temperature ranging from 99°F to 103°F. Since pyrexia may result in restlessness or stupor, this could have contributed to the fall.

The urge to use the bathroom was given as a reason for attempting to get out of bed by 64 (45%) patients. Reaching for bedside objects accounted for 52 (36%) of cases and miscellaneous reasons, e.g. a drink of water, for 16 cases or 11%. In 11 instances (8%) the patient got up for no known reason. Snell says "the excretory functions were the main hazards to hospital patients". The high incidence of falls in the older age group can be attributed to the frequency of urinary problems and to poor sleeping habits.

Repeated falls occurred in seven of our patients, five having two falls, one having three and one four falls. The interval between falls varied from 1-59 days, but in most cases was within an eight day interval. The multiplicity of falls in the same patient supports the concept of an "accident prone" individual. Such individuals are said to have unexpressed feelings of hostility or guilt and injure themselves frequently. They are more likely to become hospital patients and to injure themselves in hospital settings.

Injuries have been classified by various workers into mild, moderate, severe and fatal. We found the grading shown in Table III more satisfactory, 85 or 60% of falls being graded 0, with no symptoms or signs, and 26 or 18% showed grade 1 injury, with pain but no detectable injury. Redness, contusion and abrasion resulted in 22 (15%) of falls being graded 2, while only 5 (4%) had lacerated wounds requiring suture, ranking as grade 3. In grade 4, three falls resulted in fracture and massive rectal bleeding occurred after a fall. No patient died on the day of injury.

Injury

Table III

Grade	Description	No. of Cases	%
0	No symptoms, no signs	85	60
1	Pain, no detectable injury	26	18
2	Redness, contusion, abrasion	22	15
3	Laceration requiring suture	5	4
4	Fracture, dislocation, massive bleeding, viscreal rupture	4	3
5	Death	0	0

The 3% of patients in grade 4, with serious injury, found in this series accords well with other studies: that of Parrish and Weil reports 4.07%, Petrovisky 3.75%, and Weil and Parrish 2.36%.

Five deaths occurred within 2-16 days following a fall (Table IV). Of these five patients, only two had grade 4 injury. One patient, whose primary diagnosis was carcinoma of the breast, died from massive rectal bleeding following a fall: there was no autopsy. The other patient had carcinoma of the thyroid with metastases: fall resulted in a pathological fracture and death occurred 16 days later.

Death

Table IV

Primary Diagnosis	Interval Between Fall & Death in Days	Grade of Injury	Major Symptoms	Autopsy
Myocardial Infarction	3	0	–	Findings not related
Carcinoma breast	12	4	Rectal bleeding	No autopsy
Carcinoma thyroid with metastases	16	4	Fracture of humerus	Pathological fracture of humerus
Lymphosarcoma	2	1	Pain	Findings not related
Pulmonary fibrosis	3	0	–	Findings not related

Conclusion

If we were to describe a typical hospital accident-prone patient, that patient would be a male over 60 in the first week of his admission to a ward-bed, occurring during the night after he received a hypnotic.

Acknowledgement

We gratefully thank Mr. Walton A. Waller, Assistant Administrator, Victoria Public Hospital, Staff of Medical Records Department, especially Mrs. Lorraine Carson and Miss Dolores Bohan and Mrs. Ruth Dennison, Director of Nursing for their valuable help and co-operation. □

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How Does Malignant Melanoma Present?

S. T. Norvell, Jr.,* M.D., F.R.C.S.(C),

C. Richard** and D. Gorman**

The following observations are based on a retrospective review of 248 cases of malignant melanoma seen in the Nova Scotia Tumour Clinic and Halifax teaching hospitals over a period of 19 years. It is estimated that these patients constitute about 75% of all cases of cutaneous melanoma seen in the Province during that period, and that the sample observed is fairly representative of the entire group.

Approximately 43% of all patients with malignant melanoma are alive 5 years after the diagnosis is made, and when appropriate corrections are made for the expected demise in a population of comparable age and sex distribution, the 5-year survival is 47%. If one considers only patients without disseminated disease, when first seen, these figures are 46% and 51% respectively.

For early melanoma managed by ideal treatment, these figures rise to 76% and 80% respectively. Thus, a diagnosis of malignant melanoma is not tantamount to a death sentence, and the benefits of early diagnosis and proper management can be demonstrated.

Sex and Age Distribution

In the Nova Scotia series there were 137 females and 111 males. This slight predominence of females is in accord with most reported series.

The youngest patient in the series was 5 and the oldest 87 at the time of histological diagnosis of malignant melanoma. The age distribution by decades is shown in Table I. The greatest numbers are found in the fourth, fifth, and sixth decades. It should be noted that children and young adults are not exempt from this malignancy.

Clinical Stage at Time of Presentation

The initial clinical stage of 245 cases is shown in Table II. The great majority of patients presented to their physician with "early" disease, that is, with negative lymph nodes and no clinical or radiological evidence of distant metastases.

Common Symptoms and Their Duration

The common symptoms and their relative frequency are indicated in Table III. Most patients for whom symptoms are recorded had more than one symptom of the primary. The 7 patients for whom "no symptoms" are recorded represent biopsies of asymptomatic lesions suspected by alert physicians.

It should be noted that increase in size is by far the most common symptom reported. "Increase in size" refers chiefly to increase in diameter, but some patients also noted elevation of a previously flat lesion. It should not be totally unexpected that growth is the paramount manifestation of a new growth.

59 patients reported colour change, usually an increase in pigmentation. Moles which become darker, however, are not necessarily malignant. A decrease in pigmentation, the development of a non-pigmented nodule in a pigmented lesion, or the finding of a variegated pattern (more than one colour) is of greater diagnostic importance.

Bleeding, ulceration, infection, and failure to heal may all be manifestations of the same biological property of malignant tumours: a lack of normal cellular adhesiveness and hence a breakdown of the integrity of the skin surface.

The duration of symptoms was recorded for 193 patients, and these are shown in Table IV. This is the duration from the first symptoms until histological diagnosis was made; hence, a long delay may represent procrastination by either the patient or the physician. In the majority of cases, however, symptoms were of less than one year's duration; in one-third of cases symptoms were present for less than three months.

Appearance of the Primary

In the great majority of cases, the primary lesion was recorded as being black or darkly pigmented (72 cases), or brown or pigmented (60 cases). In 29 cases the primary was recorded as being red, colourless, or only slightly pigmented. Other colours, including the diagnostic "variegated pattern", were recorded in 59 cases.

The gross appearance of the primary was so variable that there may not be a typical lesion. The majority presented as slightly elevated lesions, often warty or irregular on the surface. Some primaries presented as ulcers, some as polypoid lesions, and some retained the classical features of a junctional naevus: "smooth, flat, hairless, and looks like a spreading drop of paint".

The size of the primary at the time of diagnosis ranged from less than 5 mm. in diameter to greater than 10 cm. The majority were 1 to 2 cm. in greatest transverse diameter.

Does Melanoma Characteristically Arise from a Pre-Existing Mole?

Some authors suggest that as many as 60% of malignant melanomas arise de novo and not from a pre-existing mole. Our data suggest the contrary.

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153 patients were able to state whether or not they had a pre-existing mole and its duration. As shown in Table V, 55 patients either had no pre-existing mole, or had a mole for less than 2 years. We may infer that the majority of these had a melanoma which arose de novo. 19 patients had a mole for 2 to 10 years, and no interpretation can be made from this group. 79 patients had a pre-existing mole for more than 10 years or "all my life", or "as long as I can remember", or words to that effect. We infer that in these patients the melanoma rose from a pre-existing benign naevus.

While most melanomas appear to arise from a pre-existing mole, a "mole" of short duration is an indication for excision-biopsy, along with the classical indications mentioned later.

Site of the Primary

The location of the primary is not of great diagnostic importance. As shown in Table IV, a melanoma may arise on any part of the cutaneous or mucocutaneous surface.

A lower limb is the most common site for malignant melanoma, and here the leg is the most frequent primary location, particularly in females.

Females are much more likely than males to have a melanoma either on the leg or on the forearm. Males, on the other hand, are more likely than females to develop melanomas on the posterior aspect of the upper half of the trunk. One can only speculate about the relation of these locations to sex of the patient.

It is of some interest that melanomas of the head and neck have an appreciably better prognosis possibly because they are noted and diagnosed earlier. Melanomas of the trunk have the poorest prognosis, possibly because they are observed late, or possibly because of uncertainty about their lymphatic drainage.

Which Pigmented Lesions should be Biopsied?

It is a mistake to ignore any pigmented skin lesion if one suspects that it may be malignant. On the other hand, since the average individual has 20 or 30 moles, a certain amount of judicious selectivity is necessary.

We have already pointed out that pigmented lesions of short duration are particularly suspect.

Moles of longer duration may be suspected on the basis of either their location, or their manifestations. Any pigmented lesion on the palms, soles, or genitalia should seriously be considered for *excision* biopsy. Even if these are not malignant, they are highly likely to be junctional naevi and therefore pre-malignant. Moles which are situated in areas where they are likely to be injured by belts and straps, by shaving, or by other repetitive trauma should be removed.

As our study indicates, an increase in size or change in colour in any pre-existing mole is an indication for excisional biopsy. Bleeding, ulceration, itching, and infection, and failure to heal likewise call for biopsy. Satellites are diagnostic of a relatively late lesion. Even fear of cancer and a number of miscellaneous and often seemingly inconsequential symptoms sometimes lead to diagnostic biopsy. A histological diagnosis of a benign lesion is often the best reassurance to the patient, and malignant transformation of a junctional naevus in a bottle of formalin is said to be exceedingly rare.

AGES AT DIAGNOSIS BY DECADES

TABLE I

AGE	NO.
0 - 9	1
10 - 19	7
20 - 29	25
30 - 39	43
40 - 49	54
50 - 59	40
60 - 69	33
70 - 79	34
80 - 89	10

INITIAL CLINICAL STAGE

TABLE II

STAGE	NO.
Unknown	19
Nodes Negative (I)	163
Nodes Positive (II)	39
Disseminated Disease (III)	13
Reported as "Denign"	11
	245

SYMPTOMS OF THE PRIMARY

TABLE III

	NO.
Increase in size	129
Bleeding	79
Colour Change	59
Ulceration	47
Itching and Infection	39
Failure to Heal	21
Satellites	8
No Symptoms	7

DURATION OF SYMPTOMS

TABLE IV

DURATION	NO.
3 months or less	67
> 3 to 6 months	41
> 6 to 12 months	39
> 1 to 2 years	31
> 2 years	15

PRE-EXISTING MOLE

TABLE V

No pre-existing mole	25
Mole less than 2 years	30
	55
Several (2-10) years	19
Many (more than 10) years	30
"All my life", "As long as I can remember", etc.	49
	79

PRIMARY SITES

TABLE VI

SITE	Males	Females	Total
Unknown	6	1	7
Head & Neck	22	21	43
Trunk	33	23	56
Upper Limb	20	25	45
Lower Limb	25	61	86
Other	4	7	11

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Trauma X – Wednesday's Child*

Edward B. Grantmyre,** M.D., C.M.

Halifax, N.S.

Trauma X is the non-sensational name being used locally for the battered child syndrome. The term battered child syndrome was chosen 20 years ago to attract attention to what was at that time a neglected clinical and social problem. The chief drawback to the use of this term is that it tends to provoke and inflame the hearer, often initiating a premature bias against the accused parents before adequate medical and legal investigation can be made. The condition has also been known in various parts of North America as the Caffey-Silverman Syndrome; the Caffey-Kempe Syndrome; and recently the Parent-Infant Traumatic Stress Syndrome.[1] It is best described as intentional physical injury inflicted on infants and young children.

The battered child and the child's parents have been extensively studied. Over 200 papers have appeared since the initial articles by Caffey, and later by Silverman. At least four books on the subject have been published, and one of these deals exclusively with the problem on the Canadian scene.[2] A local Opportunities For Youth grant enabled a team of medical, law and social work students to assess as a summer project many aspects of this problem in Nova Scotia in general, and in Halifax in particular. The report of their findings is expected to be available early in 1973.

Van Stolk[2] has estimated that in Canada there are from 4,275 to 7,000 children who each year suffer from significant intentional physical abuse, and of this number 100 to 150 die from their injuries. In Halifax at the I.W.K. Hospital an average of 15 cases are seen yearly which is a little less than expected from the experience of other centres.

In approximately 90% of reported cases the perpetrators of this trauma are the parents, most often the mother. Gil points out that in the usual family situation the involvement rate in incidents of child abuse is higher for fathers and stepfathers than for mothers, but since about 30% of reported abuse incidents occur in the single-parent female headed household the mother is numerically most often the perpetrator[4]. In less than 10% of cases, siblings, baby sitters, boy friends of mother, cleaning women and other parent substitutes have been identified as the assailants. These parents or parent substitutes represent all races and all cultural, social, economic and educational levels. Fewer than 10% are psychopaths. Most series have a higher proportion of cases from poor socio-economic circumstances. It should, however, be appreciated that often the final "diagnosis" is the result of judicial decision and it has bee the experience of this author that the poor are seldon represented by legal counsel in Family Court. Conversely in one of the most severe cases of Trauma X seen at th I.W.K. Hospital (fractured cervical spine, fractures of 2 ribs, fractures of both humeri and both femora in variou stages of healing) a shrewd counsel for middle class parent convinced the court that the traumatic episodes may no have occurred while the infant was being cared for by th parents.

There is no single pathognomonic finding indicative o Trauma X. Rather, the suspicion must be based, like man in clinical medicine on a summation of findings. Kemp lists thirty-five factors that may suggest this diagnosis[5]. Th most important of these have been summarized as follows

WHEN THE PARENT

1. Presents contradictory history.
2. Has delayed unduly in bringing child for care.
3. Is reluctant to give information.
4. Projects cause of injury onto a sibling or third party.
5. Presents a history that does not explain the injury.
6. Has been reared in a "motherless" atmosphere.
7. Has unrealistic expectations for the child.

WHEN THE CHILD

1. Has an unexplained injury.
2. Shows evidence of poor overall care.
3. Is unusally fearful.
4. Shows evidence of repeated injury.
5. Is seen as "different" or "bad" by the parents.
6. Shows evidence of "characteristic" x-ray changes.

The "characteristic" x-ray change are well described i most recent radiologic texts. All the traditional signs o trauma such as fracture, dislocation and cartilaginou injuries may be present, but to see these in various stages o healing is indicative of repeated traumatic episodes. Smal triangular chip fractures of the metaphyses involving severa long bones are common findings, and may be seen immediately after injury. Later the long bones may b surrounded by traumatic involucrums due to subperiostea hemorrhage suffered at the time of the initial injury. Th differential diagnosis includes congenital insensitivity t pain, osteogenesis imperfecta, scurvy, rickets, infantil cortical hyperostosis, and usual childhood fractures.

When the condition is strongly suspected, it is recom mended that the child initially be hospitalized both for hi own protection and to allow full assessment of th

*Presented at the Atlantic Provinces Orthopedic Society Meeting, November 1972.

**Director, Department of Radiology, I.W.K. Hospital for Children.

situation. *The physician is then required by law*[6] *to report his suspicion of child abuse to the Director of Child Welfare or the local Children's Aid Society.* This same legislation protects the reporting physician from legal action by the parents. The importance of reporting this suspicion cannot be overemphasized. Studies indicate that if the physician does not accept this responsibility, 25% to 50% of the children will be permanently injured or killed within the next several months.[7] More personal reasons for reporting are that physicians in Canada have been fined for non-reporting and that four physicians in the United States have been sued for $5 million by an estranged father for failing to report their suspicions regarding the multiple episodes of trauma his son had received.

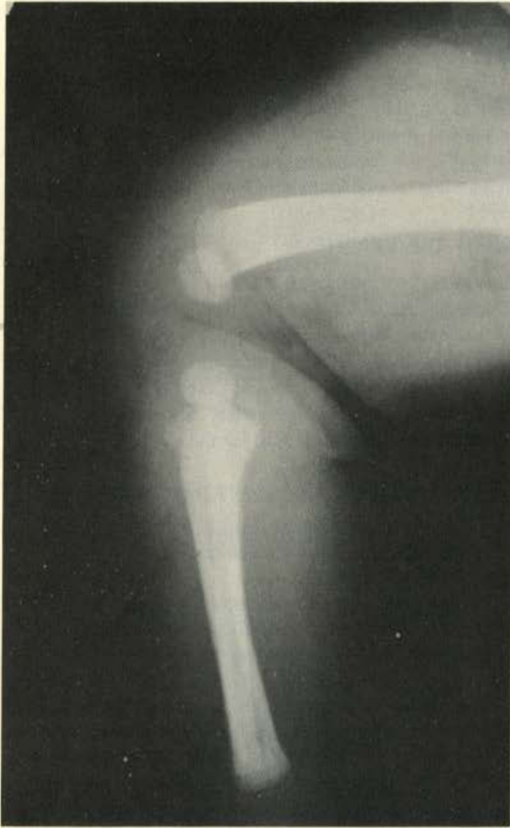

FIGURE 1

Initial film of knee reveals a fracture through distal epiphyseal plate with displacement of the ossification centre posteriorly. Small metaphyseal chip fractures are evident along the distal femur and proximal tibia.

Treatment of the child's injuries is usually straightforward. Treatment of the hostile environment that caused these injuries is usually most difficult. The most favorable circumstances would be the finding of a baby-sitter or other parent substitute who is responsible for the abuse, as they could be easily removed from the environment, but this is seldom the case. Usually and unfortunately, it is one of the parents, and now it becomes the responsibility of the Children's Aid Society or the Director of Child Welfare to decide on the appropriate course of action. If the family situation has positive factors, and if the parents agree to undergo counselling and close supervision the child may be returned to them. If the social and family circumstances are hopeless the child will be made a ward of the Children's Aid Society by the Family Court, and then placed in a foster home.

The prevention of Trauma X in our present violent society will not be easy. Current trends recognizing the worth of the beleagured child-rearing mother will help. Perhaps the easier methods of contraception, and the current trend toward smaller families will also be of value. Day-care centers may even give the "shack-wacky" parent an opportunity to regroup her resources in the struggle against material, emotional and social inadequacies. Yet, it must be emphasized that there is no evidence to support the proposition that all people are potential child batterers. The child batterer is felt to be a particular kind of person who is unable to identify with the child and who has unrealistic expectations concerning behaviour and discipline of children.[3]

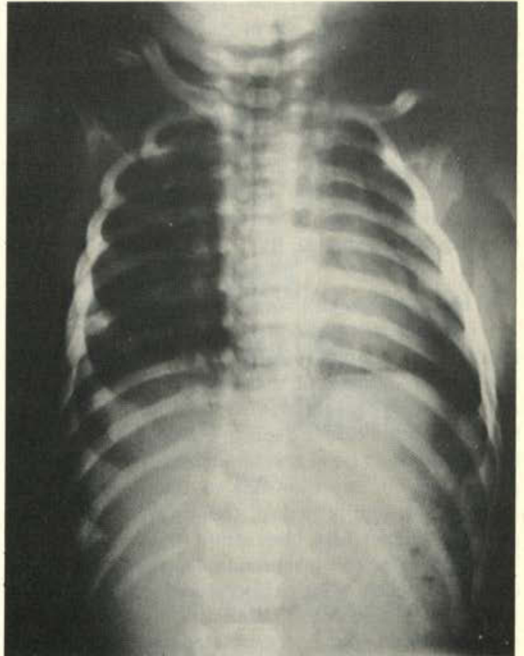

FIGURE 2

Supine film of thoracic cage reveals recent fracture of right clavicle and recent fracture of right 11th rib. Healing fractures of right 5th and 6th ribs, and the left 9th rib are also evident.

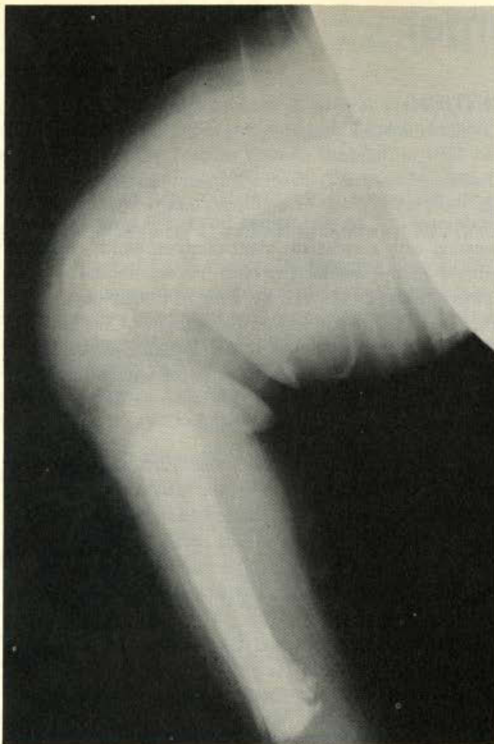

FIGURE 3

Recheck film of right knee 8 days later reveals the traumatic involucrums surrounding the shaft of the femur and tibia, as well as the original injuries.

The lack of time, space and special expertise have restrained me from discussing at any length the role of the social worker, the psychiatrist, child protection services, the courts, the police and a host of other factors related to this subject. The interested reader will find extensive bibliographies in any of the books referred to in this article.[2,4,5,7]

In summary, the physician must be suspicious of the possibility of the diagnosis of Trauma X in any infant or child where the extent of injuries is considerably greater than expected by the history. Parental factors common to most of these cases of child abuse have been discussed. The moral, legal and ethical responsibility of the physician to report these cases has been emphasized. □

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Pregnant Rh Negative Patients

It is known that Rh sensitization may occur following spontaneous or therapeutic abortions and ectopic pregnancies, as well as deliveries. Therefore, Rh Immune Serum Globulin is to be given to all Rh Negative women with such early pregnancy complications or terminations providing the patient does not have – D Antibodies in her blood. It is necessary to have blood testing done before any termination of pregnancy. Therefore, routine Rh testing should always be done at the time of the patient's first visit to her physician.

Rh Committee of the
Medical Society of Nova Scotia.

Bill Turner

AN APPRECIATION

During last weekend the news media recorded the tragic heart-breaking details of the sudden death, by car accident, of forty-five year old Doctor William Turner and his eleven year old daughter Sally, on Saturday 13 May, 1972.

The name "William" undoubtedly appears on his birth record, school registration, marriage certificate, university diplomas, drivers' license, and other official documents, but unofficially and affectionately he was "Bill" or "Doctor Bill". In our club it was highly formal to address him as "Gyro Bill".

In any group or crowd Bill Turner would command attention on account of his large physical stature and his beaming smile. His mental, spiritual, and social qualities were correspondingly great.

Gyro International enrolled Bill as a member of the Moncton Club effective 21 October 1968. He did not have to take training in the aims of Gyro because friendship was inherent in his nature, and he had long experience in the application of the Gyro Key Words: -

"Power: Symbolizing the power of friendship in our human relationships.

"Poise: Demonstrating the steadiness of friendship in the time of trial.

"Purpose: Keeping the balance wheel of friendship forever active in the daily lives of more men."

Bill was a great asset to the Gyro Club. He enjoyed its varied activities whether they were regular meetings, card games, lobster picnics, dinner dances, or Christmas parties for the children. He was witty and enjoyed thoroughly pranks played on him by his colleagues, but he could be relied upon to even the score, and usually to add a little interest.

The deaths of Bill and Sally Turner occurred on Saturday, immediately prior to Mother's Day, and thus during part of the Family Weekend. This coincidence intensified the pathos of the tragedy because Bill was devoted to his wife Avis, his four daughters, and his son. At the time that Bill joined the Gyro Club he and Avis had four children, all daughters, and the first name of each started with the letter "S"; Susan, Sandra, Sally, and Sonja. Shortly after joining the Club there were rumours that there might be an addition to the Turner family in the near future. Most Gyros and Gyrettes who were present at the annual Christmas party, will recall that Santa had a gift for each child, but only one adult was favored. If my memory is correct Santa called for "Wee Willie Turner". It was whispered around that Santa's agent who provided the gift was a Gyro friend, an obstetrician by profession.

In due course a son was born, and maintaining the traditional "S" he was named Scott. Bill came to a Gyro meeting with a series of infant pictures, which he passed around to the members present. He was indeed a proud father! It was announced by some of the Gyros of senior citizen status, that it was an old custom of the Moncton Club that a new father had to sing a solo. Eventually after much teasing and coaxing, and with the vocal assistance of Chairman Gyro Fred Forbes, Bill entertained the club in excellent voice and with great gusto.

At the 1971 Christmas party wee Scott was scampering all over the place, but most often towards the Christmas tree, with an amazing exuberance of spirits. He had a small blanket held tightly to one side of his head. As Gyrette Almeda remarked he was just like "Linus" in the "Peanuts" column. Bill goodnaturedly chased and repeatedly retrieved Scott for the duration of the party. I am sure there must have been many Gyros and Gyrettes who were thinking that at Scott's age, Bill Turner must have been just such a goodnatured, vivacious, hyperactive boy, bubbling over with enthusiasm.

Avis and Bill utilized the music at dinner dances to the utmost. They danced together most gracefully, with great agility and with obvious pleasure. It was a joy to watch them.

The Turner family worshipped at the Bethel Presbyterian Church, where Bill was not only a member of the Board of Trustees, but also the treasurer, and where he sang in the choir.

In writing about Bill Turner's professional life I hope you will tolerate references to me and mine. As Executive Director of The Moncton Hospital from 1955 to 1970 I had an unusual opportunity to assess Bill's "knowledge in the theory and practice in the arts, of medicine". A native of O'Leary, P.E.I. Bill attended Mount Allison University, and then studied at the Medical School of Dalhousie University. At that time students at Dalhousie had to have credit for one year of rotating internship before getting their doctorate of medicine: three months in each of Medicine, Surgery, Obstetrics, and Paediatrics. In an agreement between Dalhousie Medical School and The Moncton Hospital, some of the final year students came to Moncton for three months experience in Paediatrics. Consequently Bill Turner interned from 2 November 1956 to 4 January 1957. He received most of his training from Gyro Claude Leighton. The hospital's report on Bill's internship would be envied by the most brilliant and industrious of medical students.

When Bill graduated and had a license to practice, he settled in Salisbury to replace Gyro Brent Stewart in

general practice. In an amazingly short time he had developed a busy medical practice extending for many miles in a radius from Salisbury.

After his valuable experience in general practice, Bill took post-graduate studies at the Victoria General Hospital, Halifax, and at the Toronto Western Hospital. In 1967 he passed the examinations of the Royal College of Physicians of Canada, and he was appointed to the Medical Staff of the Moncton Hospital, as a specialist in Internal Medicine.

The impact of Bill Turner on The Moncton Hospital was that of a human dynamo. In a trice he had a very busy practice, with a great number of consultations requested by his colleagues. He was the sparkplug in developing the Cardiac Intensive Care Unit, which has saved from death a countless number of patients with heart afflictions, especially coronary thromboses.

It is amazing the number of medical doctors and their families, who depended on Bill Turner for medical care. Thus he was a physician's physician, a most flattering honor. He was brilliant in diagnosis and therapeutics. From my personal knowledge, on two occasions when I was acutely ill, I can vouch that Bill Turner exuded confidence in his patients, and comfort to the spouses or relatives. At the time of his death hundreds of people said simply, but with intense feeling, "He was our doctor".

However Bill Turner's contribution was not confined to the practice of cardiology and internal medicine, because he was a natural, enthusiastic teacher. He conducted course after course after course for nurses, technicians, and interns. He stressed especially irregularities of the heart beat, and the emergency care of heart arrests and failures. The lectures were started for nurses in the Cardiac Intensive Care Unit, but soon they became available for all nurses on the staff, and to student nurses. Later nurses came from the George Dumont Hospital, University of Moncton, Highland View Hospital of Amherst, Stella Maris Hospital of St. Anne de Kent, Miramichi Hospital of Newcastle, and other institutions. I found it quite touching that of the class of about 60 enrolled at the time of his death, there were three nurses from his home town of O'Leary, P.E.I. It seems incredible that a physician with such a huge practice could spend so much time teaching. Undoubtedly Bill Turner had a profound influence on health services and life saving procedures not only in Moncton, but also throughout the Maritime Provinces.

Involved in Bill's practice, there was a tremendous demand on his time for acute emergencies, by day, night, and weekends. Only a man with a rugged constitution could stand such a strain.

Some of the Gyros and Gyrettes of my generation may remember Alexander Woollcott as a great critic of drama, and literature. In the early days of radio he had a weekly broadcast called "The Town Crier". It began and ended with the ringing of a handbell like the town criers of old. In the broadcasts, Woollcott read gems of English literature, and interesting biographical sketches. In a compilation of "the minor masterpieces of my own day," entitled "The Woollcott Reader," published in 1938, he included the story "A Doctor of the Old School" by Ian Maclaren. Woollcott called it "the most moving and uplifting tale ever told in the English language". In an "afterword" Woollcott wrote "If, in some crisis of flood or fire, I knew I could keep, in my flight to safety, but one of the sacred writings in this book, there would be no hesitation, I should choose 'A Doctor of the Old School'." I have read the story many times, but I got it out again after Bill's death. I want to draw attention only to two short extracts.

One morning during this past winter, I went to the Hospital before 8:30 a.m. to get a newspaper. Bill Turner was there, looking tired, but prepared to start his daily duties. He had been working all night in the Cardiac Intensive Care Unit to save the life of a professional man, whose heart had ceased beating on three different occasions (cardiac arrest) and had to be started again by electrical stimulus. The patient has returned to work! In the story of the Doctor of the Old School the doctor's friend Drumsheugh saw him preparing to try to save a life. In his Scottish dialect the friend said, "It gar'd ma very blood rin faster tae the end of ma fingers just tae look at him for a' saw noo that there was tae be a stand-up fecht atween him and deith, and . . . a' kent wha wad win." (It caused my very blood to run faster to the end of my fingers just to look at him for I saw now that there was to be a stand-up fight between him and death, and I knew who would win.) Bill Turner had hundreds of such fights with death!

In the final chapter of Maclaren's story, written after the others had first been published, and entitled "The Mourning of the Glen," Lachlan Campbell, an aged man, had the final words. ". . . the doctor's judgment has been ready long ago; and it is a good judgment, and you and I will be happy if we get the like of it. It is written in the Gospel, but it iss William . . . that will not be expecting it." Jamie asked eagerly, "What is't Lachlan?" The old man, now very feeble, stood in the middle of the road, and his face once so hard was softened into a winsome tenderness. "Come, ye blessed of My Father . . . I was sick, and ye visited me." □

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"Let us hope that sometime we may stop and make deliberate choice of a sweeter, quieter, friendlier life, and by cutting down our social tasks and intellectual recreations, make time for rest and domesticity, and for remembrance of others whose houses and lives adjoin our own."

Anon.

Not Always Cheerless

A. E. Murray, M.D.
Halifax, N.S.

Officially appointed or not, coroners drawn from the ranks of blacksmiths, postmasters and other lay job categories were not necessarily the most appropriate individuals to preside over inquests involving accidents, homicides, suicides and deaths in provincial medical hospitals.

In 1894 this realization, coupled perhaps with the euphoria of scientific advance and some pretty hard criticisms of evidence adduced at inquests into deaths at the Nova Scotia Hospital, saw the province's first medical examiner appointed – but for Halifax-Dartmouth only.

It was some years before the present Fatalities Enquiries Act was proclaimed and the county coroner system was abolished; fifteen years, in fact, after I was appointed medical examiner for Halifax-Dartmouth.

While the county coroner system was still in effect, I recall being asked to perform autopsies and to give evidence at many less than formal inquests. Once, in a village about twenty miles from the city, I was the first witness called in an enquiry into the death of an individual whose unrecognizable body had been washed ashore.

Hardly had I taken the stand, when the inquest faced an unexpected postponement. There was no Bible. I could not be sworn.

The local police mounted an expedition to locate one and finally returned with the news that "Mrs. Gray next door has one . . . but she won't let us take it out of the house."

The inquest was then formally adjourned to the somewhat bemused lady's home where I was sworn in on the family's brass-bound Holy Book which weighed in at approximately ten pounds.

A certain spontaneity marked many inquests in those days and the ability to play things by ear was a valuable attribute.

I remember a young Negro girl, friendless and alone, who, after being delivered of a child in Halifax, set out for the nearest community where she might find sympathy and assistance from people of her own race. She did. They kindly took her in.

Tragically, the next morning the baby was dead, the coroner was advised, and I was called upon to do an autopsy. After viewing the remains I told the coroner I thought no autopsy necessary.

When the inquest was ready to proceed, a lack of jurors looked like it might force a postponement. However, it appeared to me that some diplomacy coupled with a judicious investment would help us all get the formalities over with and prevent the prolongation of grief. A young boy was dispatched to inform the villagers that jury duty would be compensated for at the rate of fifty cents per juror. Within ten minutes we had forty men present.

In testifying I was asked to give an opinion on the cause of death. Were foul play or neglect involved? I replied that, in my opinion, death was caused by pneumonia.

Immediately, the foreman of the hastily impanelled jury jumped to his feet. "That's good enough for us, boss," he said.

The inquest was over.

Some matters of detail also tend to slip by even the most diligent officials.

Once I was subpoenaed to give evidence in a Supreme Court trial on motor manslaughter – now termed criminal negligence. The jury was selected. The trial began, and I was placed on the stand and sworn.

Suddenly, after some red-faced consultation among court and police officials, the trial was adjourned to a later date. It appeared that one element was missing. The accused was still in jail. Somebody had forgotten to bring him to his own trial.

Suicides are more common than usually supposed. Not only is the incidence of suicide higher than many believe, but the methods are often remarkably complex and devious.

At a recent International Convention of Coroners and Medical Examiners in Louisville, Kentucky, I watched one of our own Canadian coroners show slides of sixty different methods of suicide he had seen. I was somewhat surprised to discover I had encountered all but one.

This involved a man who had crashed into a concrete abuttment with his car. Under normal circumstances it might have been considered an accident. However, when a policeman opened the car door, he was overcome by cyanide gas. To make doubly sure, the victim had opened a tin of cyanide in the car just before striking the abuttment. Since that date I have seen one case of cyanide poisoning.

One interesting point to note is that the physician in attendance or the medical examiner must fill out and sign a death certificate assigning the cause of death in conformation to an international list of causes of death.

I have seen many certificates over the past two or three years where the cause of death is certified as cardiac arrest. This is, of course, the most frequent terminal event of death . . . but it does not appear on the international list.

In about 6,500 cases of my experience the police and I have been successful in establishing the identity of the deceased in all but one. This was the badly decomposed

body whose demise came under formal consideration following the use of Mrs. Gray's Bible.

There were no hands on the body. The feet and the lower jaw were missing and there were no teeth in the upper jaw. Identification was clearly impossible.

I have been on the witness stand many, many times to give evidence. Usually, the medical examiner's evidence is not subject to much cross-examination. In any event, the evidence is usually underground at the time. However, in giving evidence it is important to use common language and to avoid medical terminology as much as possible.

I was once giving evidence in a murder trial and came under cross-examination by a well-known lawyer, now deceased.

In looking over my report, he said, "Doctor, this report is dated April 3. When did you do your examination?"

"On April 1," I replied.

He asked, "Did you write your report from memory?"

"No," I said, "I made notes at the time."

"Do you have them with you?"

"No, I'm sorry, I haven't."

"Are they available?"

"Yes," I said, and court adjourned for half an hour while I went to my office for them. I then returned to the stand and handed my notes to the examining attorney.

Now, my handwriting is never at its best and, in cases like this, it is usually very much abbreviated.

The examining attorney glanced at my notes.

"Jesus!" he said. "No more questions."

Speaking of paper work, I try to keep it down to a minimum. However, not everybody does and I recall a case in which I was involved a year or so ago.

A man had died at sea and the body was put ashore in Halifax. As far as I know, my appointment as medical examiner does not cover deaths at sea. However, there appears to be nothing in international law or any other law I can find that does cover such cases and the body cannot be moved unless somebody signs an official death certificate . . . although a log book entry covers the burial of a body at sea.

However, I performed an autopsy on this man, ascertained he had died of a myocardial infarction and duly reported the cause.

I heard nothing more on the matter for about three months when I received a letter from a New York legal firm which bore the names of about forty lawyers on the margin. The letter was a request for forty-seven copies of my autopsy report.

I replied that I would be happy to conform at $5 per copy.

I haven't heard from them since.

Perhaps these reminiscences will help to change the impressions of some that the medical examiner's job is a gruesome, cheerless business.

True, it has its roots in a tragedy common to us all, but it also has its brighter and interesting side. □

Physician Self-Assessment – ANSWERS

Question No.	Correct Answer
335	E
401	A

POSITION WANTED

Dalhousie Graduate, 1970, age 29, married, wishes a general practice opportunity in Nova Scotia, preferably Halifax or South Shore area. Completing third year of experience in Armed Forces in May, 1973.

Reply: P. Clark, 81 Regal Buto Ave., C.F.B. Petawawa, Ontario.

HAVE YOU MOVED?

Since it takes three weeks to change our mailing lists, members are advised to give us early notice of any change of address. This will ensure continuity of their subscription to **The Bulletin** and enable their Medical Society to give them the best possible service.

As notification of **C.M.A.J.** is not automatic, members are also requested to notify C.M.A. direct. Their address is:

C.M.A. House, P.O. Box 8650, Ottawa, Ontario K1G 0G8.

The doctor and his leisure

Building Model Ships

R. Ballem*, M.D.
Halifax, N.S.

Webster's New Illustrated Dictionary defines "leisure" as: "unoccupied". Naturally, we will not all agree with Mr. Webster's definition. However, most of us will feel and probably accept that leisure should be enjoyable – should satisfy.

May I suggest that building a model ship

CAN SATISFY: • • • •

- One's curiosity as to history, geography, politics, navigation, tides and currents, continental drift, pollution, trade and commerce, or at least stimulate one's interest in these subjects.
- A creative urge, almost a necessity. To take a mass of different, naturally occurring material, (flat, round, square, linear, soft, hard, flexible) and combine them into a functional whole – a ship.
- A feeling for beauty – the line of a good hull, the set of the rigging; the shape and symmetry of a functional ship is a beauty that can be seen, felt – almost heard.
- A challenge. To finish what you start. May I suggest starting with a relatively simple model – not a small one for instance. The rigging of a three-inch model of the "Victory" is a frustrating experience, yet a twenty-six inch model would take the better part of a year.
- The need not to waste time. To make certain that the "unoccupied" hours are occupied in a profitable and pleasurable activity.
- The need to say "Thank You" to someone personal by giving them something into which you have put something of yourself. A model ship is quite an acceptable gift for an office, waiting room and home.
- The need to put part of your mind on a "neutral" problem, while the rest "re-sorts" your more immediate perplexing personal problems.

The two models illustrated are examples of the two most common methods of construction. Fig. 1 – the rigged sloop is a solid block, shaped and contoured. Fig. 2 – the un-rigged hull is built up as a real ship with keel ribs, planks, etc. Fig. 3 – merely shows the detail of the bridge seen in Fig. 2.

A beautiful example of model ship building can be seen in the Citadel Museum in Halifax, The "Annie E. Wright"

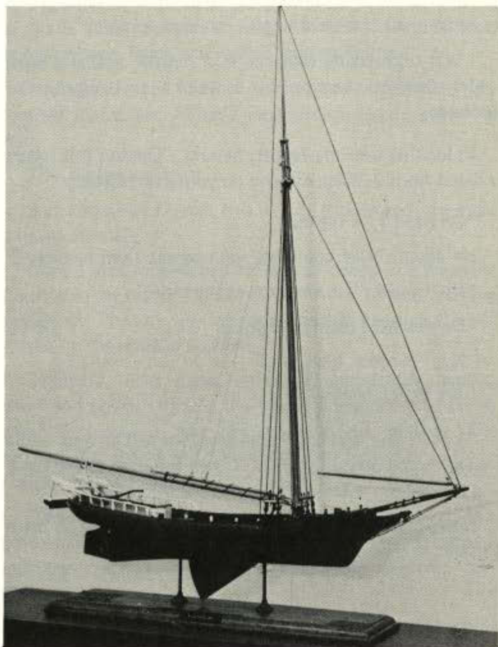

FIGURE 1
A rigged sloop

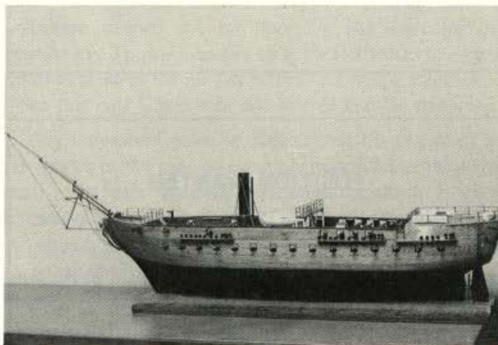

FIGURE 2
Unrigged hull

*Dept. of Anaesthesia, Victoria General Hospital and Dalhousie University.

built by W. W. Marshall of Clifton in 1885. Also to be seen is a 286 year old model of the St. Albans – a ship of the line. The real ship was built from this model. Rear Admiral H. F. Pullen has contributed two fine models of sturdy ships of the coast, Tancook and Labrador Whalers.

There is a delightful new book "The World Of Model Ships and Boats" by Guy R. Williams. It is beautifully illustrated and describes the fascination of model ship building.

Catalogues of models and kits are available from Prestons' 120T Main Street Wharf, Greenport N.Y. 11944; Model Shipways, Bogota, N.B., or from the Hobby Shop, Barrington St., Halifax.

A few suggestions come to mind. Don't try to work when you are hurried or tense.

LePage's Bondfast glue dries fast and holds well. It pours white but dries colourless.

When completed the model should be put into a case. This protects it from physical damage and dust which can build up on shrouds and running rigging and change a thread into a string in a short time. The case can be glass or plastic. The latter can be obtained in any shape or size from Maritime Plastics, Agricola Street, Halifax.

Good Luck! I hope building a model ship brings to you as much pleasure as it has to me.

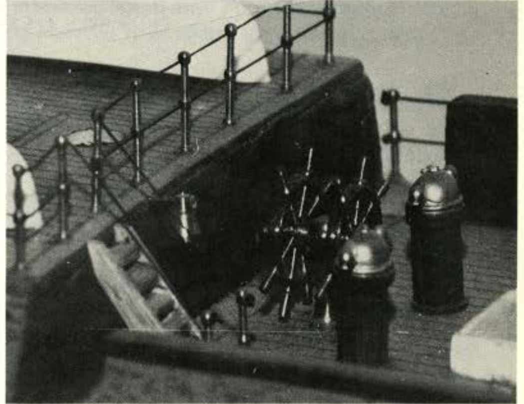

FIGURE 3
Detail of bridge of model shown in Fig. 2.

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The W. K. Kellogg Health Sciences Library orders all the books and serials which are favorably reviewed in major medical journals. The items are purchased to lend to both practicing physicians in the Atlantic Provinces and to students and staff of the Dalhousie University Medical School.

The new Saunders' serial *Clinics in Gastroenterology* was reviewed in *Lancet,* October 28, 1972, as follows:

"...the aims of the series ... [are] to indicate to the non-specialist the modern techniques available and their application and evaluation in diagnosis and treatment, and the influence of modern developments on our clinical judgment. The contributions have in great part measured up to this task ... No library or gastroenterologist should be without this series, and many non-specialists will be greatly stimulated by it." Topics covered thus far: Exocrine Pancreas, January 1972; Crohn's Disease, May 1972; and Vascular Diseases of the Biliary Tract, September 1972.

ASTHMA AND HAY FEVER by Oscar Swineford, Jr., a C. C. Thomas title, was reviewed in *New England Journal of Medicine,* October 12, 1972:

> "... From the clinical standpoint, the physician may find in this one monograph detailed answers to almost any question he may pose relative to the acute or long range care of the asthmatic patient in the form of medication, diet, diagnostic testing, preparation of allergic extracts, immunization schedules or history-taking outlines. There are answers to many basic questions here that will not be found in any other current or older textbooks. Although classifications of types of asthma have long been and still are under debate, the author discusses his nine types of causes of asthma and outlines the criteria by which they can be readily diagnosed. When each type of cause is listed in the asthma-gram of each patient, comprehensive appropriate therapy becomes obvious ... ASTHMA AND HAY FEVER should provide interesting, informative and often entertaining reading for students of medicine ..."

The library is also subscribing to a *"Canadian Consumer"* for the evaluation of medical equipment titled *Health Devices.* As stated on the cover of the first issue in April 1971, the objectives of the Health Devices Evaluation Service are to improve the effectiveness, safety, and economy of health services by:

1. Providing independent, objective judgment for selection, purchase and use of medical devices, instruments, equipment, and systems.

2. Functioning as an information clearinghouse for hazards and deficiencies in health devices.

3. Encouraging the improvement of medical devices through an informed marketplace. The evaluation studies – ranging from orthopedic litters and electric beds to electrocardiograph monitors and laminar flow operating rooms – are of use to both practitioners and hospital purchasing staffs. For example, in the study of sphygmomanometers, 27 U.S. and imported mercury and aneroid units were evaluated by brand names. The mercury units were more accurate, and the higher priced U.S. aneroid models performed better than the cheaper imports. The article, of course, provides detailed evaluation. A subscription to *Health Devices* costs $250 annually; and reproduction without prior written permission is forbidden, for the subscription income is the only source of funds for this non-profit program which is designed to benefit the entire health community. Even though the availability is thus limited, more health care personnel should be aware of this important journal.

If these or any other items you have seen reviewed recently interest you, please telephone, telex, or write. □

Blood Gas Analysis Answers:

The correct interpretation is "Partly Compensated Metabolic Acidosis with borderline Hypoxia".

The low pH (normal range 7.360 – 7.440) indicates acidosis.

What is the reason for the acidosis? The Base Excess (Normal Values – 2.5 + 2.5 mEq/L) and the Standard Bicarbonate (Normal range 22 – 26 mEq/L) are both depressed. This is the only apparent reason for acidosis. Since both these parameters reflect the metabolic status of the patient, a diagnosis of metabolic acidosis is in order.

The low PCO_2 (Normal Range 36 – 46 mmHg) Indicates the attempt at compensation through hyperventilation.

The PO_2, while just on the borderline (Normal Range 90 – 100) is rather low in view of the hyperventilation. (As determined by the low PCO_2) which could be expected to raise the PO_2 slightly.

Synopsis of Psychotropic Drug Interactions

Patrick Flynn,* M.D., F.R.C.P.(C)

Halifax, N.S.

Several of the commonly prescribed psychopharmaceutical agents have important adverse effects when they are taken with other medications. Physicians are advised to be vigilant with their prescribing at all times, but especially so in the situations described below.

MAJOR TRANQUILIZERS (Neuroleptics) **PHENOTHIAZINE COMPOUNDS** e.g. Chlorpromazine & similar Drugs. **HALOPERIDOL TYPE COMPOUNDS** e.g. Haldol **THIOXANTHINE COMPOUNDS** e.g. Navane Tarasan	Generally, Adverse Effects with: (1) All potentiate (to a lesser or greater extent) other medications and drugs which act on the C.N.S. e.g. hypnotics, analgesics, anaesthetics, anticonvulsants. (2) Alcohol is best severely restricted. (3) Should not be given, as a rule, to persons involved with the non-medical use of hallucinogens
TRI CYCLIC ANTI-DEPRESSANTS (Dibenzazepine Compounds) e.g. Amitriptyline Imipramine, etc. Admixtures of these e.g. Etrafon Group, Triavil, etc.	Generally, Adverse Effects with: (1) Mono Amine Oxidase Inhibitors e.g. Parnate, Nardil, etc. (except under Specialists care) (2) Pressor Amines & Stimulants e.g. Noradrenalin, Amphetamines (3) Guanethidine & Bethanidine type Anti-hypertensive agents. e.g. Ismelin, Esbatal, (4) Alcohol Severely Restricted.
M.A.O.I. Anti-depressants e.g. Parnate Nardil	Generally, Adverse Effects with: (1) Tricyclic Anti-depressants (see above). (2) Medications containing vaso-constrictors & sympathomimetics. e.g. Ephedrine, Phenylephedrine, etc. (3) Foods containing significant amounts of Dopamine & Tyramine e.g. Aged Cheese, Pickled Foods, Pods of Broad Beans, etc. (4) Anti-Parkinson drugs, eg. Artane. (5) Many potentiate C.N.S. depressant drugs. e.g. Hypnotics, etc. (6) Antihypertensive Agents. e.g. Aldomet, Reserpine, Guanethidine. (7) Propranalol & other B-blockers.
MINOR TRANQUILIZERS (Anxiolytics) e.g. Meprobamate Valium Librium, etc.	Generally, Adverse Effects with: (1) May Potentiate Sedative & Ataxic effect of alcohol. (2) Unpredictable response with other C.N.S. depressant drugs.

Physicians are advised to make themselves conversant with the medication manufacturers' literature. □

*Associate Professor of Psychiatry, Dalhousie University, Halifax, Nova Scotia.

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Kapseals containing 0.5 Gm. phensuximide; fruit-flavored aqueous suspension containing 300 mg. phensuximide per 5 cc.

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ACCOMPLICE TO SUICIDE

The doctor who smokes a cigarette in the presence of a patient is practicing bad medicine. He is putting the lie to every report on the dangers of cigarette smoking. By his action he is condoning the smoking of tobacco. He is telling the patient that it is not all that bad to smoke. He is at once destroying the effectiveness of every anti-smoking campaign. He is telling the patient, far more effectively than words can do, that cigarettes are not "coffin nails".

The anti-smoking campaign of the government and the respiratory diseases associations, have been dismal failures. Canadians are smoking more cigarettes than ever before. Ever increasing proof has accumulated naming the cigarette as an important etiologic agent in a host of diseases. This information is not hidden away in the depths of some medical archives. It screams from the TV screen, from our daily newspapers, from magazines and from respected journals.

Why then has the public not put aside the cigarette for the poison that it is? Why, in the face of absolute proof that smokers have such a greater chance of getting a fatal disease, do they ignore this fact? Everyone who can read, or even hear, knows that smokers get lung cancer, throat cancer and heart attacks at a much higher rate than non-smokers. Is there any longer doubt that a peptic ulcer will heal much faster and more permanently if the patient desists in the use of the weed?

And yet, the anti-smoking campaign has been ineffectual. If the recent report of the increased per capita use of cigarettes is true, then we have to assume that these campaigns are not the best approach.

It is my contention that only by precept, not concept, will a change take place in the smoking habits of our fellow citizens. We, as doctors, can do several things that will be effective. First, and foremost, we who still have the habit must drop it. And we must do it now. We should do it for our own sake and our children's as well as for our patients. Secondly, we must insist that there be no smoking in our offices. I have done this and have met with no resistance or complaint. And finally, we must become evangelists in the field of preventive medicine generally and anti-smoking in particular.

It is totally unrealistic to expect patients to stop smoking while their trusted and "learned" medical adviser puffs away on a weed. Can we blow smoke in the face of the patient with emphysema while telling him that he must stop smoking? Must we instruct every case of URI, asthma, chronic bronchitis, etc. that they must not smoke? Not only is this our medical duty but we dare not do otherwise. But we must do it without the reek of tobacco about our heads, without the tell-tale stain on our fingers and without a cigarette in our hands.

I wonder how many happy, healthy years could be added to the lives of all our fellow citizens if doctors, as a whole, rid themselves of this filthy habit.

Think about it!

M. E. Burnstein

CARCINOMA LUNG

Nova Scotia Provincial Cancer Registry

	1965	1966	1967	1968	1969
Total patients	126	147	175	163	165
Male	103	124	149	142	141
Female	23	23	26	21	24
Cases too advanced to be treated	36	28	48	52	46
Surgical treatment	5	20	20	16	19
Radiation	62	54	73	71	70
Combined Surgery & Radiation	7	12	6	8	15

The above figures are self-explanatory. Carcinoma of the lung is a serious problem. The number of patients who can be considered eligible for cure by therapy is very small.

J. A. Myrden, M.D.
Director, Nova Scotia Tumor Clinic

Personal Interest Notes

Citation for Senior Membership

Mr. President, **Dr. Thomas Bernard Murphy** is proposed for Senior Membership in The Medical Society of Nova Scotia.

For almost 40 years, Tom has served well the people in his area of Eastern Nova Scotia. A dedicated, compassionate physician, he worked skillfully and successfully for his patients. No effort was too much to ask of him; no service too menial. In fact, he is still working and giving of himself after recovering from a serious illness.

Tom was born at Louisburg at the turn of the century. His early schooling was obtained there. He worked in the mines at Glace Bay and at the Steel Plant in Sydney. Graduated from, and taught at Saint Francis Xavier University in Antigonish in the twenties. He graduated from Dalhousie and came to Antigonish to practice in 1934 where he has resided ever since. He has been a bulwark of strength to the Medical community in Antigonish, giving of himself unstintingly in the cause of better medical care.

Tom and his charming wife, the former Frances Fitzgerald of Sydney, have made many, many, contributions to the life of the Antigonish community.

They have six wonderful children; one son in medicine, one in law and one teaching; the three daughters have been teachers – all perpetuating the motif of service of their parents.

As President of Maritime Medical Care Inc. for two consecutive terms, Tom made a tremendous contribution to the business side of Nova Scotia medicine.

For this, and the many other contributions as a citizen, physician, husband and father, we wish to thank and honour you, Tom Murphy, with our most sincere best wishes for happiness all your days.

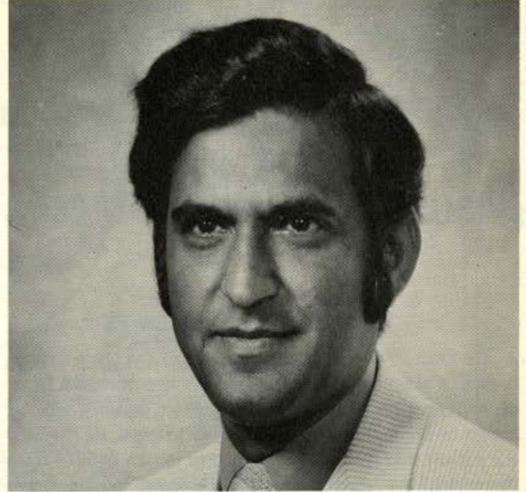
G. L. Silver, M.D.

On December 1, 1972, Merck, Sharp and Dhome in collaboration with the Cape Breton Medical Society, sponsored a Symposium on Hypertension. Visiting Lecturers were **Dr. Vidt** of Cleveland, Ohio, **Dr. Reudy** of Montreal and **Dr. John Stewart** of Dalhousie University.

On behalf of the Cape Breton Medical Society we have been asked to thank these doctors and also extend a sincere vote of thanks to Merck, Sharp and Dhome for sponsoring such an enlightening programme.

CAPE BRETON POST'S MAN OF YEAR

Dr. S. M. A. Naqvi



The Cape Bretoner of the year, in our opinion, is **Dr. Syed M. Ali Naqvi,** the debonair vascular surgeon, whose dedication and energy has helped transform medical facilities in industrial Cape Breton.

The selection of Dr. Naqvi is based not only on the exceptional surgical skill which has saved many lives but also on his role in the establishment of the Intensive Care Unit at City Hospital.

Dr. Naqvi was born and educated in Pakistan, where he graduated from the Dow Medical College in Karachi in 1958.

After internship with the Civic Hospital in Karachi and the Harlem Hospital in New York, he came to Nova Scotia in 1960.

Resident general surgeon at Victoria General Hospital in Halifax from 1960 to 1962, he served on the staff of New Waterford Consolidated Hospital from 1962 to 1965. For the next three years he was resident general surgeon at Mt. Sinai Hospital in New York, and in 1966 was an assistant at Mt. Sinai School of Medicine in that city.

He is a member of Nova Scotia Medical Societies and Canadian Medical Association, American College of Surgeons, Royal College of Physicians and Surgeons of Canada and numerous other organizations.

His appointment to City of Sydney Hospital was approved in 1969.

Reprinted courtesy of the Cape Breton Post.

Dr. V. H. T. Parker, 80, of Stellarton died December 2, 1972. Born in Belle Isle, Annapolis County, he received his medical degree from McGill in 1917. He opened a general practice in Stellarton in 1920 where he practiced for over 50 years. Dr. Parker was a Senior Member in both The Medical Society of Nova Scotia and The Canadian Medical Association. Our sympathy is extended to his widow and daughter.

Dr. Joseph A. McDonald, 66, of Glace Bay died December 29, 1972. Born in Iona, he graduated from Saint Francis Xavier University. He then attended Dalhousie University where he graduated in medicine in 1933. He was a member of the Glace Bay Medical Clinic and practiced in the Glace Bay area for 36 years. Sincere sympathy is extended to Mrs. McDonald, his daughter and sons. □

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