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The Relief of Pain and Suffering, A Quest that Never Ends

"Pleasure is often a visitant, but pain clings cruelly to us."

—Keats

The puzzle of pain is far from solved. Fortunately, renewed interest by investigators such as Melzak has recently stimulated renewed interest in the subject. Like Socrates whose dialectical arguments lead to a whole school of inquiring philosophy. Melzak did not accept the simple minded answers of the past, but constantly sought new explanations for unravelled mysteries. New ideas such as the gate theory of pain, the mechanism of pharmacological agents on the nervous system and the effect of electrical stimulation and anaesthetic agents on the nervous system, have been extensively investigated.

Study of the physiological aspects of pain has lead Melzak to suggest three major physical dimensions of pain namely, sensory discriminative, motivational affective, and cognitive evaluative, subserved by specialized systems of the brain. The complex function of identification, evaluation, and selective modulation of impulses are combined and effective responses are co-ordinated according to each individual's experience and particular circumstances. Many of the basic mechanisms have been elucidated including the role of the reticular formation and the limbic system.

Amongst the practical applications of these investigations have been electrical stimulation to relieve pain, the study of acupuncture as a science, new neurosurgical procedures to relieve pain and the development of new anaesthetic and analgesic agents.

In this *Bulletin* we are fortunate to have important and classical contributions on pain. Dr. D. K. Murray, Halifax ophthalmologist, who has recently been elected a Senior member to The Medical Society of Nova Scotia, outlines the history of pain alleviation in a scholarly fashion. He scans the evolution of anaesthesia from the time of Genesis, when Adam lost a rib, to the occasion when an apothecary administered chloroform to a woman in childbirth in Pictou County in 1848. Dr. D. K. Murray's contribution was recently discovered by his son, Professor Murray of British Columbia, and was written over thirty years ago.

Claims for the first administration of an anaesthetic have been hotly disputed, but credit has been given to Crawford Long of Georgia whose exploits are recorded both by T. J. Murray and Emerson Moffitt in this issue. Some anaesthetic history notes were compiled by George Thomson in *The Nova Scotia Medical Bulletin*, but credit for the discovery of McNeil Parker's performance as being the first Canadian to carry out an amputation under anaesthesia must be given to T. L. Flemming, special Collection Librarian at the W.K. Kellogg Health Sciences Library, Dalhousie University. In a search on the history of anaesthesia, he discovered the reference and reported it to the editor of the *Canadian Anaesthetist Society Journal*.

Dr. Moffitt's contributions add another dimension to the story and emphasize what an important role anaesthetists play in the development of surgery. Last year some forty thousand anaesthetics were administered in the Halifax teaching hospitals alone.

Future developments depend on research and dedication of interested physicians and physiologists. An entertaining account of early days of anaesthesia has been written by Richard Gordon and includes a vivid description of Robert Liston amputating a limb from an unanaesthetized victim in twenty-six seconds, whilst the students applauded.

Dr. T. J. Murray reminds us of the important part patients have played in history. Revaluations about Napoleon's hemorrhoids, Rommel's hypertension and George III's porphyria remind us that pain and suffering can effect the mighty at inappropriate moments.

The Brompton mixture contains cocaine and gin traditionally, and has been used with advantage to relieve the prolonged penetrating pain of malignant disease. The mixture is sometimes distrusted by physicians unacquainted with its use and we are grateful to Dr. J. F. Filbee for specifying how it should be effectively prescribed.

There are billions of sufferers from low back pain whose exact mechanism remains a riddle. Kernahan *et al.* report on low back pain in a horseback rider is particularly interesting as it is one of the few clinical investigations of this subject. Equestrains are a determined breed, considering that even severe or almost disabling pain should not dissuade them from continuing the sport.

The extent to which non prescription drugs are available and used to relieve pain and anxiety is revealed by Flynn and Opie, making it important that all physicians should be aware of this possibility when investigating patients with problems of drowsiness and unexplained symptoms.

Finally let us not forget the pain and suffering inflicted by man's inhumanity to man. Amnesty International have records of torture of men, woman and children in 60 different countries. The medical profession cannot escape its responsibility in this terrible degradation of Human Rights. The conference on Abolition of Torture in Paris in 1973, established a medical commission.

In Canada a medical group exists which carries out investigation and tests on people who seek refuge here. A report to the *Canadian Medical Association Journal* gave findings in 11 child refugees who had been tortured.

Amnesty International deserves support from physicians as it is one of the few defences against the rapidly spreading epidemic of torture around the world and it will give guidance to doctors involved in this miserable aspect of pain and suffering. □

B.J.S.G.

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Dr. Margaret Churchill

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Dr. Margaret Churchill was born in Barrington, Shelburne County in 1934.

She attended Dalhousie University in Halifax, Nova Scotia for both her under graduate and medical education. She graduated in 1960 and went on to do her residency in paediatrics at the Montreal Children's Hospital and the London Ontario Children's Hospital. After receiving her certification in 1964 she opted for a general practice in paediatrics in Yarmouth, Nova Scotia. Three years ago she became a consulting paediatrician at the Yarmouth Regional Hospital.

Dr. Churchill has been in Nova Scotia and a member of The Medical Society of Nova Scotia for fifteen years. Although her work has been demanding, she has made a considerable contribution to Society business. She has also served as a member of the Provincial Medical Board for the past six years.

Dr. Churchill is a former vice chairman and president elect of the provincial body. She has also held the office of Chief of Staff of the Yarmouth Regional Hospital.

Her interests have extended into the community of Yarmouth where she speaks on Child Abuse and children's health, "pretty well whenever they want me to," as she puts it.

Dr. Churchill enjoys diving, canoeing, and travelling, but her practice and new position as president of the Society now fill most of her hours. □



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Some Notes on the History of Pain Alleviation

D. K. Murray,* M.D.,

Liverpool, N.S.

The following observations are neither the result of research nor are they original but can be found in many current volumes. They have been set down not because most of our readers are not fully acquainted with them, but because they make an interesting review. With these reservations, and in view of the plea for more contributions from the profession at large to the *Bulletin*, we make so bold as to submit these notes.

The use of anaesthetics, to alleviate the pain of surgical operations or childbirth, was entirely unknown before the middle of the 19th century. Prior to that time operations were performed only from direst necessity, and the fully conscious victim was restrained by physical means to prevent his escape under the surgeon's efforts, and he was compelled to meet the situation with as much fortitude as he could command. This barbarous state of affairs, once accepted as inevitable, can now be happily compared with the present humane oblivion produced so easily by any one of a fairly large number of agents.

The discovery of anaesthesia for surgery and obstetrics took place in 1846. It depended not so much upon the employment of a new drug, as upon a new administration — i.e. inhalation. It is purely academic to observe that with the employment of agents of anaesthesia, the provinces of surgical and obstetrical procedures became without boundaries or ceiling.

The deadening of pain by soporific potions was known even to some primitive people. Helen of Troy, we are told, cast "nepenthe" into the wine of Ulysses. The Talmud of the Jews speaks of a narcotic "Samme de Shinta". There are also the "drowsy syrups" of the Arabian Knights. Opium and Indian Hemp were known to the Egyptians and Greeks, — and mandrake, to the Hebrews and Babylonians. Biblically, "Rachel sought mandrake of Leah" (Gen. xxx: 14-16). It is uncertain for what purposes she used it. Mandrake wine was used by Dioscordies, surgeon in the army of Nero. Mandrake was popular essentially during the middle ages until the 16th century. Pare, the noted French surgeon found it inefficient as an anaesthetic and it is wryly recorded in A.D. 1525, that he preferred not to so torture "poor wounded men". He simply lashed his patients to the table so that their writhing would not interfere with his work.

The surgeons of the 18th and 19th centuries sometimes intoxicated their patients with opium or alcohol when the procedures necessitated freedom from struggling. But the surgeons of pre-anaesthetic days depended largely upon speed. Thus we read of the sleight-of-hand affairs of a surgeon-general in the Hanoverian army at the time of Napoleon "amputating an arm while one might take a pinch of snuff".

In all of this no mention is made of the child-bearing woman. Soporific potions may have been used in ancient

times, true enough, but no one ever troubled themselves about the pains of the parturient. Indeed the efforts to avoid the parturient pains sometimes called forth punishment. The Greek Goddess, Acternia, it is noted, terrified by her mother's suffering at her own birth, sought from Zeus, the favour of eternal virginity. Subsequently she seduced Endymion and was punished for her early prudery by a truly god-like superfecundation; she became the mother of fifty daughters at one time.

There are a few recorded instances of painless childbirth during profound intoxication induced for reasons other than those of analgesia. One such case occurred in a woman brought into the Hôtel Dieu of Paris, 1818. Another was the celebrated case of Countess de St. Geran, who was rendered insensible by a draught given to her by the midwife; she was then delivered and her child abducted before she regained consciousness. We find, however, no definite record of effort to alleviate the pains of parturition as such.

There is a prescription for relieving painful childbirth which is set forth in a manuscript of Zerobabel Endicott of Salem, in 1860. Endicott's prescription is here given in full. "For sharp and difficult travail in woman with child, take a lock of Virgin's hair of any part of ye head, of half ye age of ye woman in travail. Cut it very small to fine powder and take 12 ant's eggs, dried in oven after ye bread is drawne or otherwise make them dry, and make them to powder with the haire, give this in 1/4 pint of Red Cow's milk or for want of it, give it in strong ale wort". There, we agree, is an attractive potion for the gastronomic mechanism of a fatigued primipara.

The pain of childbearing has always been woman's heritage. The pain and fortitude with which she has met it are not new with modern civilization. Biblically, it said of the parturient, (Jer. iv:31) "For I have heard a voice as of a woman in travail—the anguish as of her that bringeth forth her first child, the voice of a daughter of Zion, that gaspeth for breath, that spreadeth her hands, saying "Woe is me now, for my soul fainteth before the murderers". As for the fortitude of women, it can be quoted (Jer. xlviii:41) "And the heart of the mighty men of Moab, at that day shall be as the heart of a woman in her pangs".

Apparently the introduction of anaesthesia to alleviate the pangs of labour, aroused a violent storm of controversy. It was science versus didactic teaching of the then known clergy — and would seem amusing were it not for the suffering involved.

Scotland has a legend regarding anaesthesia. The, mother of St. Kentigern, of Glasgow, was impregnated under a soporific potion and without her knowledge or consent. In consequence, as a punishment, she was cast down from the top of a high hill, but wonderful to state, she was not hurt. Her tormentors were not satisfied with this evidence of Divine intervention and she was then set adrift on the Firth of Forth, whereupon she floated safely across to Fife and was rescued by St. Servanus. In due time she was safely delivered of a

*This article was written by Dr. Murray several decades ago when he had a general practice in Liverpool, N.S. During the past 28 years he has practised ophthalmology in Halifax, N.S.

son — later to become the famous St. Kentigern. Having a saint whose history was so closely associated with childbirth, may have given the clergy some sensitiveness on the subject. At any rate, it is a historical fact that in 1591 a lady of rank, Eufame MacAlyane, sought the assistance of Agnes Sampson for the relief of pain at the time of her son's birth. Agnes, tried before King James for her heresy, was condemned as a witch and buried alive on the Castle Hill of Edinburgh. Again, in the 19th century, the Scottish clergy arose — this time to consume by fiery condemnation the practice of a physician, one Dr. James Y. Simpson. This man, however, less submissive than the lady of history, turned and with their own weapon of religious interpretation, silenced the clergy and cleared the way for the progress which was to change the way of life for womanhood in the vital function of parturition. More of Simpson anon.

Reference to the events leading up to the general use of agents of anaesthesia are in order at this point.

Sir Humphry Davy really fired the opening gun in the controversy over anaesthetics. In 1800, he observed, following some experiments with nitrous oxide on himself, "As nitrous oxide in its extensive operation appears capable of destroying physical pain, it may probably be used with advantage in surgical operations in which no great effusion of blood takes place".

Forty-four years later, in 1844, Horace Wells, of Hartford, Connecticut, began to use this gas in dentistry. Thus, he was the first man to make practical application of anaesthesia. His observations were based on the fact that students, taking the gas in lecture room demonstrations, did not appear to mind the fall or slight injuries received in falling or staggering against the furniture. Some years later a death occurred while he was giving nitrous oxide. This unfortunate incident caused Wells to withdraw from practice; he became melancholy and eventually took his own life.

Wells had reported the progress of his work and as cocaine was not in use until 1879, one can imagine the extensive fields which were suddenly opened up to dental surgery. Well's friend and former partner, William Morton, of Charlton, Massachusetts, was on the lookout for a suitable agent for anaesthesia. His colleague, Dr. Charles Jackson, Harvard Medical School, had observed the above noted circumstances as applied to the mild "Ether Frolics" in which students oft times indulged. Horton, aware of its possibilities, tried it on the family dog and finally anaesthetized himself. The following description of his first patient is in detail. Sept. 1846. "At this moment the door bell rang and Morton admitted a man named Eben Frost, whose bandaged face with mingled hope and consternation is familiar to all dentists. He asked if it were possible to mesmerize him and readily consent to inhale ether, when assured that it superseded mesmerism. To the job of the operator and the astonishment of the patient, the attempt was perfectly successful". As I say, this was in 1846.

Morton was a medical student as well as a dentist and after the unqualified success of the first professional venture with ether, his mind quite naturally turned to its possibilities in surgery. Now the event with which we are all familiar. Morton prepared for two weeks and then invited Dr. Warren, senior surgeon at the Massachusetts General Hospital, Boston, to permit him the opportunity to give a demonstration of the properties of ether on a patient undergoing a surgical

operation. To this request, Dr. Warren acquiesced and the date was set for October 16, 1846.

It is history that the demonstration was abundantly successful in every respect. The very newness and originality of the phenomenon left those concerned without a name for the agent or the state. An appeal to Oliver Wendell Holmes was rewarded with the words, "anaesthetic", the agent to produce insensibility; "anaesthesia", the state of insensibility.

Forthwith, be it sadly noted, Morton and Jackson attempted to capitalize on their efforts by trying for a monopoly on the "ether rights" to a given community by issuing permits to the physicians for a fee ranging from \$37 to \$200, according to the size of the locality. This highly questionable state of affairs was vigorously resented by the rank and file of practitioners who still recognized the odors of sulphuric ether in spite of the patent name of "letheon", which decorated the product.

Jackson and Morton soon parted company, and each selfishly sought acclaim as the discoverer of anaesthesia. The friends of Wells, now deceased, who had used nitrous oxide in practice, completed the vigorous three cornered controversy. The battle raged for some years and a wag eventually suggested that a monument be raised to Jackson and Morton with the word "e(i)ther" inscribed on the pedestal.

In 1854, a bill proposing an appropriation of \$100,000 to the real discoverer of anaesthesia was actually up for its final reading before the Senate. At this stage, a Senator Dawson arose and stated that it had been brought to his attention that ether had been used by Dr. Long in Athens, Georgia, at least four years previous to Morton's demonstration at the Massachusetts General Hospital. In consequence of this declaration, the hectic period of altercation over anaesthesia quietly ended. Dr. Long was a country practitioner known only to the few in the locality in which he practised. The bill for the first operation under anaesthesia is still preserved, made out to one James Venable; it is a charge, including anaesthesia, of \$2.00. The prime motive in his communication to Senator Dawson was to still the ferment aroused by the then nation wide controversy.

Now to return to Dr. James Y. Simpson, Professor of Obstetrics at Glasgow University. Here, apparently, was a reformer with both feet set solidly on the ground and also blessed with a healthy disposition toward argument. He was among the first in Europe to employ ether in obstetrics, but he looked further afield in the hope of obtaining a less irritating agent and one that would be less offensive to the patient. He and his colleagues finally chose chloroform as the most promising possibility. He published his first paper on its particularly beneficial action in childbirth in the year 1847. Immediately he was engulfed by a violent controversy as to the propriety of abolishing labour pains, and was denounced from pulpit and by pamphlet.

Many otherwise sensible folk were led by their religious scruples to doubt the propriety of inhaling chloroform. The clergy insisted that the pains of mankind was the ordained lot of man — to prevent it was sacrilege. One clergyman said, "Chloroform is a decoy of Satan, apparently offering itself to bless women; in the end it will harden society and rob God of the deep, earnest cries which arise for help in the time of trouble." He submitted that mother instinct would suffer. He drew a picture of a drowsy debauch during which a child was brought into the world. He insisted that there was something

imbued into the child during the agony of labour, which was good. This was to be lost, said he, if anaesthesia was employed.

Simpson's rebuttal is a masterpiece of its kind. It was written in 1847 — listed under the heading "Answers to the Religious Objection Against the Employment of Anaesthetic Agents in Midwifery and Surgery". His keen and sound judgement, as is evidenced by the arguments he sets forth in defence of his beliefs, are as inimitable as they were original for this time. His best argument was that there had always been objection to innovation. He cites the turmoil over vaccination as one of the high points. "Pestilence", said he, "was supposed by the clergy to be a visitation from God and originates in man. Vaccine was produced by man and was therefore a daring and profane violation of the holy religion". Another opponent of vaccination added that "since her daughter had been vaccinated with cow-pox that she coughed like a cow and grew hair over her whole body". Another said vaccination was discontinued in a certain part of the country as all vaccinated men bellowed like bulls. Simpson reasoned that the objectors to chloroform were analagous to the vaccination opponents.

Simpson completed his paper with a piece of almost irrefutable logic, and certainly one of his most amazing. Said he, "Those who urge, on a kind of religious ground, that an artificial or anaesthetic state of unconsciousness should not be induced merely to save frail humanity from misery and tortures of bodily pain, these individuals forget that we have the greatest of all examples set before us outlining this very principle of practice. I allude to that most singular description of the preliminaries and details of the first surgical operation ever performed on man which is contained in Gen. 11:21, "and the Lord God caused a deep sleep to fall upon Adam, and he slept: and he took one of his ribs and closed up the flesh instead thereof." In this remarkable verse the whole process of a surgical operation is briefly detailed. But the passage is principally striking as affording evidence of our Creator himself using means to save poor human nature from unnecessary endurance of physical pain.

Simpson carried the weight in his arguments and silenced the religious objectors and he then turned to lay low his medical opponents with equally masterful rhetoric. The tone of derision, which he had carefully excluded from his papers on religious objections, he let loose with fury on his medical objectors.

Simpson felt that their main resentment was due to the fact he was attempting to change the order of the things established. His principal opponent was Dr. Meigs of Philadelphia. Dr. Meigs insisted that the pain was physiological and therefore essentially to be endured. "The pain of childbirth," said he, "was a desirable, salutary and conservative manifestation of the force of life".

Simpson submitted that the same argument would certainly be applicable to the first use of the carriage as a means of locomotion; if the traveller's feet blistered as he walked, it would have to be endured as the will or wish of the Diety. He must, therefore, forego the practical impulse to seek a ride as a means of alleviating the dolorous pedal extremities. He stated that most of such travellers would not endure the logic of such a medical advisor, but would seek vehicular locomotion in good time. He argued that the parturient, having travelled along the way a great distance,

was entitled to the extra artificial lift at the end of the fatiguing journey.

Simpson published a paper two years after his first notes on chloroform in childbirth. In it he was able to report its use on 50,000 cases in labour and upon those undergoing surgery. Simpson had established this advance toward the alleviation of pain and suffering. The greatest influence on all opposition, and there was plenty of opposition, was in 1853, when the world was astounded to hear that Queen Victoria accepted chloroform in the birth of her seventh child, Prince Leopold. Thereafter most formal opposition ceased.

Simpson was eventually knighted. Sir Walter Scott proposed a coat of arms for Simpson consisting of a "wee naked bairn" and the motto (chloroform in mind), "Does your mother know you are out?".

It is with pride that we may state that all the fortitude and vision did not stay in the British Isles with the exodus of tens of thousands of its people to the new world — in this reference — Nova Scotia.

Mark you, Simpson's first rebuttal to his opposition was in 1847. Queen Victoria was administered chloroform in 1853. In 1848, in the small town of Pictou, Nova Scotia, the gentleman, J. D. B. Fraser, apothecary, pioneered the production and the use of Chloroform in Canada. In his old family bible there is this entry, "Robert Peter Fraser, Born March 22, 1848. At the birth of this, my 7th child, chloroform was first used in Canada during childbirth".

Thus it is recorded that only a few months after the first known instance in the world of chloroform being used at childbirth, the little known gentleman in that small pioneer town was making and using a substance which was to quickly become a boon to mankind, unparalleled up to that time. □

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Let's talk

Anaesthesia in Nova Scotia

IN THE BEGINNING

Emerson A. Moffitt*, M.D.,

Halifax, N.S.

While Joseph Priestley discovered the "hilarious" effects of nitrous oxide in 1772, it was not until the 1840's that the "anaesthetic" effects of it and other gases were utilized.¹ A rapid chain of events began on March 30, 1842 when Dr. Crawford Long first gave ether vapour to a patient in Georgia, but he did not report it at the time. Horace Wells, a dentist, used nitrous oxide in his practice as early as December 1844, but when demonstrating to a Harvard medical class, he was not successful. The classic date remembered by most is October 16, 1846, when a dentist, cum medical student, William T. G. Morton, anaesthetized a man with ether vapour, at the Massachusetts General Hospital. In those days when news could travel only as fast as sailing ships, it is remarkable how quickly anaesthesia came to Nova Scotia.



The scene in the Etherdome in the Massachusetts General Hospital on October 16, 1846, as depicted later.

The Ether Story is from a fascinating book on the life of Daniel M. Parker, a respected medical practitioner of Halifax from 1845 to 1895, which is in the Kellogg Library at Dalhousie.² In 1895, Dr. Parker was reminiscing on practice in 1845. We hear him speak:

"But few of the surgeons now living in Nova Scotia can have anything like a correct idea of the difficulties which had to be contended with operative surgery half a century ago. In protracted and painful operations the patient often had to be strapped to or held on the table by continuous muscular effort on the part of assistants.

It was soon after operating on a distressing case of this character (which operation I was obliged to finish on

the floor, as it was impossible to restrain and keep a man of his strength quiet on the table from which he had thrown himself), that I became aware of the fact of the discovery, at Boston, of sulphuric ether as an anaesthetic.

Lawrence Van Buskirk, a dentist, practicing in Halifax at the time, as soon as he learned that ether was being used by inhalation there in practical dentistry, with commendable enterprise, visited Boston and familiarized himself with its use. On his return having a case that required amputation of the femur, I went to Van Buskirk's office, and after discussing the matter fully, asked him to administer ether to me, that I might personally have some knowledge of its action. He consented; and very shortly the exciting stage was upon me, and I was floating through space, suspended or upheld like Mahomet's coffin, between heaven and earth. The next day he . . . gave my patient ether, and in two to three minutes she was unconscious and insensible to pain. The limb was amputated . . . and the poor woman taken . . . to her bed. I told her the operation was over and the limb removed. When she fully took in the situation she was overcome with gratitude, and in a well pronounced Hibernian dialect expressed her thanks to God and then to the medical men who surrounded her. I, too, felt very grateful, when it was thus practically demonstrated to me that exemption from suffering could be promised to thousands and millions, who in the future should seek to be relieved by the surgeon's knife. This, I believe, was the first case operated on in Nova Scotia under an anaesthetic." End quote. The scene in the Etherdome in Boston was relived at the Halifax Dispensary: "Gentlemen, this is no humbug."

Parker never did give a date but it must have been the spring or summer of 1847. One must accept his statement that this was the first anaesthetic in Nova Scotia since he knew about the next "first" related to chloroform. But the interval must have been amazingly close.

The Chloroform Story may be summarized thus.³ James Simpson introduced the chloroform for obstetrics in Edinburgh on November 4, 1847.⁴ Consider the time, after publication of his accomplishment on November 10, for a sailing ship to go from Glasgow to Pictou. On March 22, 1848, Mr. R. P. Fraser, a pharmacist, gave chloroform to his wife in Pictou for birth of their son. He had manufactured the drug himself. News travelled fast even in those days and was followed by Scottish ingenuity.

However, the sailing time to Halifax apparently was even faster as *The Presbyterian Witness* of February 5, 1848 reported "Dr. Almon amputated the thumb of a woman in the Poor Asylum, Tuesday morning, in the presence of Dr. Parker of this city, and Dr. Brown of Horton. This case is published not for the purpose of inviting attention to the

*Professor and Head, Department of Anaesthesia, Dalhousie University, Halifax, N.S.

operation, but to the effects of the agent employed to prevent pain. The chloroform was administered by inhaling from a soft rag applied to the nose and mouth for a few minutes. The patient very soon became insensible to pain, and the operation, occupying perhaps ten minutes, was finished before sensibility returned". Dr. Almon also amputated a leg on March 11, with the patient having chloroform. The chloroform was made by the same Mr. Fraser of Pictou. Notice that Dr. Parker took part in both first cases; obviously he was a prominent practitioner of his time.

Thus it started. Let us skip over the next 60 years and look in the *Maritime Medical News* of 1906.⁵ In it are sections on Anaesthesia, Post Anaesthesia Acetonuria (from delayed chloroform poisoning) and Ether (lung complications after). The Anaesthesia article begins:

"A great deal of unrest is still manifested in the profession with regard to anaesthetics. New anaesthetics such as somnoform, ethyl chloride, combinations of morphia and scopolamine, have been enthusiastically taken up by some, but in many cases given up again with dissatisfaction. Meanwhile deaths have been reported even under the so-called safe anaesthetics, and the ordinary general practitioner turns again to his ether and chloroform."

Seventy-five years later, we have abandoned ether and chloroform but still the parade of new drugs goes on.

Two more brief glimpses of "first in Nova Scotia" will suffice. Both are reports by surgeons: full time anaesthetists were few and far between. In refuting "the recent claim of our Cumberland County friends", N. H. Gosse⁶ reported that in March 1928, spinocaine (novocaine) had first been used at the Victoria General, presumably by Dr. Hogan "in his Division" (Anaesthesia?). In 1934, V. O. Mader⁷ said "During the past three months, I have had the opportunity of using . . . Evipan soluble . . . in twenty-two cases. Although this experience is not sufficient to warrant definite conclusions, I feel that a preliminary report of this new intravenous anaesthetic is justifiable".

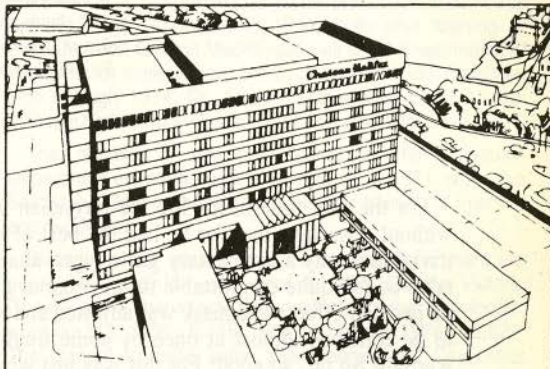
That same year, 1934, Lundy first used pentothal sodium intravenously at the Mayo Clinic. The age of smooth induction and modern anaesthesia began there. It has never looked back. All of you who had a tonsillectomy or other operation with an ether or chloroform induction as a child, surely would agree.

The article following this one, from this Bulletin in 1927, is to me not only crystal clear evidence of the superb powers of English expression of that anonymous physician; it also brings back from the deep recesses of memory, the myriad of visual sensations, even stark terror, of an open-drop ether anaesthetic in 1928 at the age of four years. Now-a-days, with the intravenous barbiturates, the lights just go out. Let us be thankful. □

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In the Shadow of the Gas Cone

The actual experience of a well-known physician who was recently under a gas anaesthesia at the Victoria General Hospital for a tumor operation. — The Editor.

“Alas! One narrow line is drawn,
That links our sunset with our dawn
In mist and shade life's morning rose
And clouds are round it at its close.
*But ah! No twilight beam ascends
To whisper where that evening ends”*

————— O. W. Holmes

For the first time in his life the physician was placed upon the operating table. And he was without conscious fear for he had the best of skilled attendants and the occasion was extremely trivial and only a momentary gas-oxygen anaesthesia would be necessary, and as he lay on the table he felt quite comfortable for the quarter grain of morphia taken an hour before was exerting its peculiar effect. The mask was adjusted and he became conscious of a sweetish odour and taste, to be followed almost at once by some tingling of the hands and feet and a sense of general warmth. So far, so good! For this was just what his hitherto impersonal studies and observations had led him to expect. But the bodily symptoms were whirled away like a band of smoke before the October gale and then, as if Hell itself had yawned wide, releasing all its fiends, there came crowding in upon him legion upon legion of *forces* — dark brown, blood red and black *forces* — indescribably confused, horribly evil in nature and malignant in intention. But the physician, clinging to consciousness, thought “They cannot prevail for I still can think.” Nevertheless, the battle was joined and at that moment the fear was born — “but what if they *do* prevail?”

Time passed with tremendous speed and in the midst of the desperate strife there came crashing into the field a monstrous creature, without form or substance, and felt only as an overwhelming force — inconceivably more evil and malignant than the whole of the legions already assembled, and this creature was armed with a great sledge hammer which he crashed back and forth with ever increasing speed and power, beating upon the head of the physician so that he knew that his complete annihilation was at hand. And he thought “If there is any *greater* power than this, I must have its aid now or I shall die,” and as he thought this thing, he called aloud for help and away on the horizon, millions of miles away so it seemed, and very faint there arose a star and about it a halo in which appeared in three capital letters the name of his Deity. And the physician's attention became fixed upon the star and he saw coming down from it and shining upon him, a cone of light, faint and dim, but as it seemed full of strength and peace and withal gray in colour — such a gray as perchance was the colour of the garment which the holy St. Francis wore on many a lonely vigil — and in that cone of light there did not appear so much as a wisp of the evil clouds which raged elsewhere all about him — “But ah! The star is too far away!” and then amidst horrible despair came utter blackness and oblivion.

Next the whole world was suffused with the same peaceful gray which had shone from the star like to the earliest light of a summer morn, and everything was quiet. The gray colour became brighter with here and there flashes of rainbow tints — a low murmur was heard, which took on a distinct and very kindly tone and memory reasserting herself, said to the physician — “These are the voices of your friends God bless them!” And he opened his eyes to see the pure white walls of the operating room and his friends the surgeon and anaesthetist bending over him. And he laughed with his friends for the conflict was over but secretly he thought, “Much have I seen of Life and of Death and passing well do I know Life. Mayhap it is that now too, do I know somewhat of Death.” □

Anonymous in *The Nova Scotia Medical Bulletin* 6:43-44, 1927.

Anaesthesia in Nova Scotia

STORY OF THE DALHOUSIE DEPARTMENT

Emerson A. Moffitt*, M.D. and Carl C. Stoddard**, M.D.,

Halifax, N.S.

While undoubtedly general anaesthetics were given regularly in Halifax from 1847 onward, no one is known to have made a special practice as an anaesthetist until the 1920's. Even through the 1930's and early 1940's, most general anaesthetics were "open-drop" in type, administered by general practitioners and internes.

The much respected man who did most to develop anaesthesia as a specialty in Halifax was Dr. Walter Muir. He came from a medical family in Truro and graduated at McGill in 1907.¹ After serving overseas in World War I, he joined the staff of Camp Hill Military Hospital as an anaesthetist. He gave anaesthetics at the other local hospitals, including the Halifax Infirmary. In 1927, he succeeded Dr. J. F. Lessel as Head of Anaesthesia at the Victoria General. Anaesthesia was a division of the Department of Surgery. Dr. Muir was also a pioneer in anaesthesia at the national level, and was involved in organizing the Canadian Society of Anaesthetists in 1920 and was its president in 1932.¹ During all his career he was on the staff at Dalhousie Medical School.

For the years just before World War II, Dr. Muir and Dr. C. M. Bethune were the primary anaesthetists of the Victoria General. With Dr. Bethune "away in the war" from 1939-45, Dr. Muir was assisted in anaesthesia by other local practitioners including Drs. M. Glube, R. B. Nichols, Hammerling and Collier.² The greatly increased need for anaesthetic services during World War II led to many new graduates taking training in that field. In fact, that event was the greatest stimulus ever, to growth of anaesthesia in Canada and the U.S.A.

From such a navy-trained background, Dr. Carl Stoddard came back to Halifax and Dalhousie, his home and alma mater. In 1947, he succeeded Dr. Muir as Head at the Victoria General. A new Department of Anaesthesia, at the Victoria General and Dalhousie, was created from the former Division. A training programme began: the first two residents were Drs. Donald Graham and Ralph Ballem.

Up until this time, anaesthetists were booked by surgeons and worked helter-skelter at all the hospitals. In 1949, separate Departments of Anaesthesia were set up at the Halifax Infirmary, Camp Hill and Children's Hospitals. In each were anaesthetists who worked mainly, if not completely, at that hospital.

In 1950, Drs. C. H. Baker and D. V. Graham were the staff at the Halifax Infirmary. Dr. Roberta B. Nichols provided much of the service at the Children's Hospital. At the Victoria General, with Dr. Stoddard, were Drs. R. Ballem, R. A. P. Fleming, C. Kincaide and A. S. MacIntosh. Two residents were Drs. J. L. MacLellan and R. Fraser. At the Children's

Hospital, Dr. A. S. Wenning joined the Dalhousie staff in 1953 and Dr. T. A. Anderson in 1956, both after training at Dalhousie. Dr. Gordon MacKinnon was Chief Anaesthetist at Camp Hill for many years prior to his death in 1968. From that time through 1974, Dr. Andre Pasquet was Chief Anaesthetist at both Camp Hill and Grace Maternity Hospitals.

The number of hospitals served by the Dalhousie Department increased by from five to six in 1971, when the Saint John General became affiliated for training of internes and residents.

Statistics of the annual case load of the Department are not to be found, for years prior to 1956. For the Victoria General alone, the volume of anaesthetics, other than locals, went like this: 1956 - 6,355; 1966 - 8,754 and 1976 - 18,221. The biggest increase came after opening the Centennial wing in 1967. For the academic year ending June 30, 1979, 46,386 patients were anaesthetized in the six university hospitals.

That size of service load, plus a greatly expanded role in undergraduate and post graduate teaching, necessitated an increase in staff that is hard to believe. In mid-1972 there were 19 staff in Halifax and four in Saint John. In mid-1979 there are 34 anaesthetists in the Halifax hospitals and eight in Saint John. We have now 19 residents in training.


How Topsy had grown! With an academic department so large, so busy and possibly more impersonal, let us reflect on our modest beginning and recognize with gratitude the persistent pioneers who started it all. □

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*Professor and Head, Department of Anaesthesia, Dalhousie University, Halifax, N.S.

**Retired Professor and Head, Department of Anaesthesia, Dalhousie University, Halifax, N.S.



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Famous Patients*

T. J. Murray, ** M.D., F.R.C.P.(C),

Halifax, N.S.

INTRODUCTION

In medicine it has often been said that the patient is the forgotten man, the unsung hero. Although this is not really true of medicine, it is a fair statement of medical history. Most writings on medical history have centered around the advances in knowledge and the development of ideas, concepts and techniques, or on the famous medical men associated with these advances. Little attention has been paid to the patients involved in medical progress.

In this 1934 address to the Royal Society of Medicine entitled, *A Landmark in Modern Neurology*, Mr. Wilfred Trotter noted that it was the 50th anniversary of Sir Richman Godlee's pioneer operation to remove a cerebral tumour. After describing the procedure, Trotter stated that the patient was a young man named Henderson who was a native of Dumfries, Scotland. He commented that it would be more usual to describe him as "the case" but he was in fact "a human being, a good man and in his way a great benefactor to medicine". He went on to state that it is a strange defect in medical history that so few of the names of such benefactors have been preserved.

There are, however, many patients whose names are well remembered. This paper considers some of the most notable. In some cases, the patient and his illness played a major role in a significant event in medicine; in others, the patient's illness may have changed the course of history and in others, the patient was a famous person, and thus his illness is of some interest.

PATIENTS WHO PLAYED A PART IN MEDICAL ADVANCES

In some of the earliest medical writing, the contributions of patients to medicine have been acknowledged. Hippocrates, for example, recorded the names of many of his patients. In more recent centuries, however, patients have received less credit. Throughout the Middle Ages and into the Renaissance their names were not recorded. The famous French surgeon, Ambrose Paré, noted the age and occupation of his patients but not their names. Later it became traditional to give the initials of patients when they were documented or published. At the turn of the 20th century, particularly in Great Britain, it was common to record the patient's hospital case number in publications and communications. In the interests of confidentiality, patients' names have not been used in the medical literature of this century.

Although patients are often seen as passive participants in the epic events of medicine, some of them have made great contributions because of the results of their management. They may not have entered the patient-doctor relationship to

benefit mankind, but many of them had this greatness thrust upon them.

A young and very brave lad named James Phipps, age 8 was the first to be inoculated with cowpox from the hand of Sarah Nealmas who had cowpox. Edward Jenner, the physician, took a brave step, which current medical ethics would not allow, when he inoculated the boy with smallpox eight weeks later and observed that no disease appeared. Jenner had experimented on his own infant son, Edward, seven years before, by inoculating him with cowpox which he believed to be similar to smallpox. Jenner performed other human experiments but when he submitted a paper on his work for presentation to the Royal Society, of which he was a Fellow for his work in zoology, it was returned with the suggestion that he not endanger his reputation by continuing such work.

Eventually it was discovered that the first people inoculated by Jenner's method were the wife and two sons of Benjamin Jestyn. Jestyn was a cattle dealer in Gloucestershire where the cowpox tradition was well known. In 1774 he inoculated his family with cowpox and in 1805 visited the Jennerian Institute in London to substantiate his claim to have been the first vaccinator. However, variolation had been known in England since 1717, when Lady Mary Wortley Montagu, the wife of the English ambassador in Constantinople, described the procedure in a letter to a friend after seeing it practised among the Turks.

Modern surgical anaesthesia began with the use of ether by Crawford W. Long in 1842 in Jefferson, Georgia; his records show the following: "James Venable, 1842, administration of ether and removal of tumour — \$2.00". Although history emphasizes the physician's contribution, the bravery of patients who subjected themselves to new and often dangerous experiments, has been invaluable. Medicine owes James Venable a great debt.

In 1844, Horace Wells, a dental surgeon, persuaded Gardner Colton, a travelling lecturer in chemistry, to give him nitrous oxide to inhale while a colleague extracted a tooth. In 1846 William Wharton extracted the tooth of Eben Frost and later persuaded a surgeon, John Colin Warren, to allow him to anaesthetize Gilbert Abbot, a man of 20 years who was to have a tumour removed from his neck. "Are you afraid?" asked Wharton. "No" was the brave answer. "I am confident and will do precisely as you tell me." We take great responsibility when we accept such cooperation and respect from our patients.

In England, the first surgical patient to receive ether was Frederick Churchill, a 50-year-old butler, who had a malignant growth on his leg and required amputation to the thigh. Peter Squire administered the anaesthetic and Robert Lisson completed the amputation in 32 seconds. When the patient recovered consciousness he did not know the operation was over, but when he saw the uplift stump of his leg he burst into tears. It was said to be a most impressive scene in the operating room.

*Text of an address to the Dalhousie Refresher Course, Halifax, October 1978.

**Professor of Medicine, Dalhousie University and Chief of Medicine, Camp Hill Hospital, Halifax, N.S. Mailing Address: Dr. T. J. Murray, Department of Medicine, Dalhousie University, Halifax, N.S. B3H 4H7.

But Churchill was not the first subject of ether in Britain. Just before he was brought in for the amputation, the anaesthetist asked if one of the medical students present would like to volunteer for the new ether anaesthesia. A young man named Shebrake, a big man with a reputation as a boxer, came forward and lay on the table. After he inhaled either for half a minute he suddenly jumped up, swung out, knocked out the anaesthetist with his fist and sent the students scurrying in fear. He soon regained his senses and the patient was then brought in.

Young Joseph Meister was attacked by a rabid dog on his way home from school. He was the first patient treated with Louis Pasteur's antirabies vaccine. He survived and worked the rest of his life as a doorman at the Pasteur Institute, committing suicide when the Germans marched into Paris.

There are many other famous patients in the history of medical advances. James G, whose surname has been lost, had a compound fracture of his left leg as a result of the wheel of a cart passing over his limb. He was the first patient to be treated by Lister's carbolic dressing and made an excellent recovery. Another interesting patient who was the subject of Lister's inventiveness was the first person to have an axillary abscess drained by a rubber tube; this patient was Queen Victoria.

The appendectomy of Edward VII by Sir Frederick Treves was a landmark in the history of modern surgery. It began a new era in which patients and physicians accepted surgery, particularly surgery in the abdomen, more enthusiastically. Sir Frederick Treves became famous for his part in the surgery, retired at age 55 with a fortune to live abroad and wrote a number of charming books on travel and reminiscences, including *The Elephant Man and Other Reminiscences* which describes London hospital life and an unusual patient, the elephant man. His patient, a young man with neurofibromatosis that gave his face and head the distorted shape of an elephant, was the topic of a play on Broadway this year.

Some patients who were also physicians described their own cases. Sydenham described his gout, Laennec his tuberculosis, Bostock his hay fever and Thomsen Thomsen's disease (myotonia congenita), a disorder in his own family. For years, Nothnagel recorded his chest pain due to angina pectoris, noting the details of his symptoms up to the moment of his death. Forsman repeatedly catheterized his own heart with his newly invented heart catheters. Dr. Joe Gilchrist, a Toronto physician who was developing difficulties with his diabetes, volunteered to have many of the first experiments with insulin carried out on himself by Banting and Best.

ILLNESSES THAT CHANGED HISTORY

One can only speculate on the role of illness in history. Nevertheless, the study of illness in world leaders is vital to understanding events.

Hugh L'Etang in his book, *The Pathology of Leadership* suggests that we tend to apply psychiatric labels to political enemies, but seldom carefully examine the mental status and physical health of our own leaders. If a leader becomes mentally unstable or his judgment fails, the whole system is designed to protect him. People around him make excuses and lie to keep his deficiencies secret. However, the need to know about the mental and physical health of our leaders has become an important issue, particularly in recent years with

the disclosure of illnesses in Hitler, Roosevelt, Stalin, Kennedy, Nixon and our own MacKenzie King, to name a few. L'Etang points out that since 1908 eleven of thirteen British Prime Ministers and six of ten American Presidents have had illnesses while in office which have incapacitated them to some degree.

Before he went to the State Department in 1961, Dean Rusk wrote about the influence unstable personalities and ill health have on those who lead the world and make decisions that may affect the survival of humanity. He stated, "The international list of those who carry great responsibility while ill is a long one, and there are fleeting glimpses of decision which good health might have turned another way". Unquestionably history has been greatly affected by leaders whose ill health impeded their judgment.

On such leader was George III. His insanity has recently been shown to be due to porphyria. As early as 1765 George III had shown signs of a mental disorder but his illnesses were kept secret by the royal household; even the prime minister did not become aware of them until later. There are well described periodic episodes of psychosis through his life and it remains an unanswered question how much Mad George's porphyria was responsible for his mismanagement of events surrounding the breakaway of the Thirteen Colonies and the American War of Independence. And the problem of porphyria continues; Richard Hunter and Ida MacAlpine have shown that the disease runs through the royal household down to the present day.

The course of history was also changed by the death in childbirth of the Princess Charlotte, the only child of the Prince Regent, afterwards George IV, and the only legitimate grandchild of George III. The documentation of her childbirth suggests that she had post partum haemorrhage and shock prior to death. If she had lived she would have become Queen of Great Britain and Ireland in 1830.

Unquestionably Napoleon's health problems also affected history. He was constipated most of his life and had been troubled for many years by hemorrhoids. At the Battle of Ligny he was forced to ride all day with prolapsed and thrombosed piles and was in too much pain to follow up his advantages in battle. While he was being treated for his hemorrhoids, the British took the opportunity to deploy themselves in a better position on the fields at Waterloo.

Despite his rest and treatment on the morning of the battle at Waterloo, Napoleon was very tired and weak. After having breakfast with his generals, he slept and awoke at eleven, just half an hour before the first shots were fired. All day he was in severe pain and could scarcely stay in the saddle. In the midst of action he retreated to his tent where his physician worked frantically to reduce his discomfort, but it was noted by those around him that he was lethargic and the battle proceeded largely without his genius for command. He was in so much discomfort that when he retreated to his tent he refused to discuss strategy and his generals were left to command alone at the height of battle.

The last years of Napoleon's life, as well as his death, have sparked medical controversy in the past few decades. The question of arsenic poisoning has been raised since hair shaved from Napoleon at his death was found to contain 10.38 parts per million of arsenic (normal being 0.8 parts per million). Another specimen contained arsenic unevenly through the hair, suggesting repeated exposure and possibly

poisoning. Was he given arsenic as a poison or as a medicine? In his day, arsenic was used to treat anaemia, malaria, arthritis and skin conditions such as psoriasis; it was also used as a gastric stimulant and Napoleon was known to have gastritis. Despite theories that Napoleon was poisoned, however, three separate autopsy reports showed that he undoubtedly died of carcinoma of the stomach.

Haemophilia in Europe's royal families also affected history, especially in Russia before the Revolution of 1917. At one period, for example, when Czar Nicholas II was in the midst of attempting reforms, his attention was increasingly drawn to his son's repeated haemophilic crises. His wife, Alexandra, whom he loved dearly, devoted all her time and attention to the boy and fell under the spell of Rasputin, whom she believed had the power to cure her son. Perhaps nothing could have prevented the onslaught of the Russian Revolution, but Czar Nicholas was in no frame of mind to make appropriate decisions during this period and his son's haemophilia was at least one of the factors leading up to the events of the Revolution.

Sir Edward Grey, British Foreign Secretary before World War I, was responsible for many diplomatic discussions and decisions attempting to prevent the threatened war. At that time he was very depressed and had been, in his own words, living a life that was purely mechanical since the death of his wife in an accident. He was widely criticized for not understanding the events of his day. But 60 years later it was revealed that he had been going blind during this period and could barely read; consequently, he could not have examined the profusion of state documents, papers and telegrams in those hectic days before the war.

Woodrow Wilson was ill much of his life and in 1913 Dr. Weir Mitchell, a famous American neurologist, thought that he could not complete his first term as President and retain his health. Despite this, Wilson ran again and retained power until 1921. In the last two years of the presidency he suffered repeated strokes and the decisions of state were carried out by a self-elected council of Mrs. Wilson, Joseph Tumulty and Dr. Grayson. Wilson was ill and alone in an upper room of the White House and the trimvirate of three gave decisions to anyone who came with questions of the President. They felt that the loss of office would remove Wilson's will to live and so they gathered round him, prevented him from resigning and tried to protect him against the public, the congress and the senate. No one was able to get evidence that would require his resignation because of ill health.

Roosevelt suffered from numerous illnesses during his life, including polio which left him paralyzed in both legs. At the end of his life, and while he was leading his country in the midst of the Second World War, he became very ill and was obviously dying when he met Churchill and Stalin at Yalta. Some feel his decisions at that time, particularly his naive kindness towards Stalin, indicated failing health.

Julius Caesar liked men about him who were fat, Stalin preferred men who were shorter than 5'1/2 feet, but Roosevelt had men about him who were infirm. Perhaps this was a reflection of his chronic paralysis and infirmity and may explain why so many of the people that surrounded him and were appointed by him were infirm, in poor health or in the failing years of their lives.

Harry Hopkins was a powerful man in Roosevelt's group. He became Secretary of Commerce and later Special

Advisor and Assistant to the President, Member of the War Production Board and Chairman of the Munitions Assignment Board. Despite this, he was dying of cancer these years. It is thought that Hopkins also had cirrhosis or haemochromatosis. Nevertheless, he was dealing with presidents, prime ministers and statesmen, attending conferences and providing very important advice and decisions to Roosevelt.

Forrestal, later to become Secretary of Defence, was appointed by Roosevelt as Undersecretary of the Navy. He developed a marked psychosis with paranoia, hallucinations, delusions and depression. A number of Roosevelt's other appointees were ill and died in office. Cordell Hull was old and in poor health when he was appointed head of the State Department. Henry Stimson was made Secretary of War at age 73 and was described as a very tired and decayed old man; could work only three or four hours a day and was slow in understanding what was going on. He was in charge and was responsible for advising President Truman in the final stages of the development of the atomic bomb. The first bomb was dropped on August 6th, 1945 and two days later Stimson resigned on medical advice.

The statement that Montgomery defeated Rommel at the second battle of Alamein is generally accepted as part of history. The fact that Rommel was in Germany for ill health is generally forgotten. Rommel had been concerned about his high blood pressure but felt that he was well enough for battle. His physicians, however, stated that he suffered from chronic stomach and intestinal disease, nasal diphtheria and considerable circulatory trouble. He was not in a fit condition to command the forthcoming offensive. Rommel had to admit that he was a sick man and return to Germany for treatment in September. Montgomery's supercharge occurred on the 25th of October. Rommel, although still nominally in charge, was in Germany and had no influence on the battle. Two days after the battle began, Rommel returned and led a masterly withdrawal west through Libya and denied the Eighth Army the real fruits of victory.

During his second administration Churchill had repeated transient cerebral ischaemic attacks and mild strokes. Between 1950 and 1952 he was unable to work efficiently and began to insist that 5-page documents be compressed into single paragraphs for his perusal. This limited his ability to consider and solve problems, and it was noted that he could not follow the trend of discussions. He refused to take a position in the House of Lords but when he had a further stroke in 1953 during a dinner for the Italian Prime Minister he became asphasic and paralyzed. Despite this he continued to appear in public, answered questions in the House and later even gave a speech. He attended a conference with President Eisenhower and the French Prime Minister. By July 1954 Churchill was no longer able to follow discussions in Cabinet and was giving speeches marred by mistakes and mispronunciation. Some of his statements were embarrassing and he had to apologize for them in the House of Commons; eventually he resigned in April 1955. By this time he was spending most of the day in bed.

One of the landmarks in the history of biography occurred in 1966 when Lord Moran published his experiences as medical advisor to Churchill from 1940 to 1965. There was opposition from the public, *The Lancet* and the Churchill family. *The Lancet* contended that confidentiality owed to the living was doubly owed to the dead. However, the historian

Dennis Borgan wrote that although he did not want to enter into that particular argument, he was seriously worried that such ill people were allowed to conduct national business.

In our country there was former Prime Minister MacKenzie King who wrote in his diaries, which were recently published, that he was living a double life. During the day he led his party, was involved in crucial debates in the House of Commons and led his country at the height of war. At night, he sensed the presence of his dead dogs and asked them to carry messages to Sir Wilfred Laurier, other dead politicians and his mother. Did his strong belief and practice of spiritualism affect his ability to run the country and decisions? Or was he able to lead a double life, with one aspect unrelated to the other?

L'Etang says, "Great men are different from you and me. When a great man fails it is difficult to decide where incapacity begins; difficult to assess the degree of incapacity; and even more difficult to tell him that he is incapacitated. The role of the doctor in regard to the small and select group of patients is unique and most practitioners have neither personal experience nor second-hand knowledge from experienced colleagues, of the correct approach and of the special problems that are involved".

ILLNESS IN THE FAMOUS

There are other patients that are interesting because they themselves were famous and therefore their illnesses command attention. Dr. Samuel Johnson, one of the great intellectuals of all time, suffered from recurrent depression during his life and scrofula, or the King's Evil, as a child; he had a lifelong movement disorder associated with involuntary vocalization which I believe to be Tourette's syndrome.

Thomas Jefferson, a remarkable genius, suffered from recurrent severe headaches that were probably cluster migraine. He found that horseback riding helped relieve the headache and he would ride off at full gallop when his severe unilateral headache occurred.

And then there was Nelson with his amputated right arm, continually painful, probably from a phantom limb, although others have suggested that it was a neuroma in the stump. He also made use of his blind eye at the battle of Copenhagen, when the flagship's signal to retreat was reported to him by his officer of the watch. Nelson took the man's telescope, put it to his blind eye, said, "I see no signal" and continued to fight.

Orthopaedic surgeons have argued Byron's deformity for a long time. They have examined the shoes and footgear that he wore to determine the shape and deformity of his foot and ankle. His deformity did not stop him from leading an outrageous and lecherous life.

The cardiac disease that killed Robert Burns at age 37 has been discussed periodically over the past 100 years. In 1926, Sir James Crichton-Browne stated unequivocally that Burns died of rheumatic endocarditis. Dr. Watson Smith reviewed Burn's illness in 1944 and concluded that he died of subacute infective endocarditis and septicemia. It would be interesting to see what the cardiologist would think of the diagnosis looking at the evidence now.

There is not much question of the cause of death of Abraham Lincoln. There is a controversy, however, about whether he had Marfan's syndrome.

And then there is the unanswered question of Charles Darwin's long period of ill health. It has been thought that he was a chronic hypochondriac and hysterical. Although others have suggested that he contracted some illness or parasitic disease in the Galapagos Islands, it is evident from his diaries that he began to experience many symptoms while he was in Plymouth for two months before the Beagle sailed. At that time he described depression, palpitations, pain in his heart and other symptoms, and he concluded that he had heart disease. For much of his life he was unable to do much work and a good day was two or three hours writing, lying on the sofa. It has been suggested that his functional disorders and psychological instability allowed him to be protected from the world and the distraction of society so that he could accumulate all his facts and information and contemplate their significance. Some have gone so far as to theorize that without this chronic hypochondriasis Darwin would not have written *The Origin of Species* or *The Descent of Man and Selection in Relation to Sex*, two publications that have changed the course of man's thought.

Darwin lived as a semi-invalid and his diaries document heart palpitations, chest pain, chronic fatigue, insomnia, depression, gastric upset, nausea and vomiting, faintness, headaches, tremor, anorexia, arthritis and chronic eczema. His daughter comments in her letters on his tanned skin which she said was deceptive for people who did not realize how ill he was. Darwin himself thought he had heart disease, but Dr. Bence Jones who examined him found his heart to be normal and recommended that he take up horseback riding as a form of exercise.

Although the question of Charles Darwin's neurotic hypochondriasis has been discussed for a hundred years, there have been suggestions of Chagas' Disease, brucellosis, malaria, duodenal ulcer, neurasthenia and other illness to explain the symptoms. Recently Watson suggested chronic arsenic poisoning; he showed that all of Darwin's symptoms could have been due to chronic arsenic poisoning considering that he had used arsenic repeatedly since he was a young man for the treatment of chronic eczema. Darwin had used Fowler's solution and a number of other arsenic solutions and Watson concludes that this accounts for his problems.

Medical problems have frequently stimulated or influenced creative development and expression. Robert Louis Stevenson's chronic ill health and invalidism from tuberculosis led him to create fantasy adventures in far off lands. He wrote such adventures constantly and at the end of his life retreated to Samoa to live out his last days in a fantasyland, where he died of tuberculosis.

Dostoevski had frequent grand mal seizures. It is evident from the prominent characters in his novels who are epileptics that his writing was strongly influenced by his illness. He described pleasurable auras before his seizures that were a form of ecstasy and heavenly experience. He felt he was special and set apart from other men because of his epileptic experiences; he said would give the rest of his life for these pleasures. Whether his ecstatic experiences were true auras has been questioned, however. He may have had psychological phenomena unrelated to his seizures.

Paganini, who looked and dressed like a devil, was reputed to have sold his soul to the devil in exchange for his prodigious violin virtuosity. But it has been suggested that Marfan's syndrome caused him to perform his legendary tour

de force of double harmonic variations on a single string and to make his violin imitate a woman's voice.

El Greco may have painted long gaunt figures because he suffered from astigmatism. Failing vision affected the later artistic output of Daumier, Piero della Francesca, Michelangelo and da Vinci. Many of the impressionist painters — Derain, Braque, de Vlaminck, Segonzac, Matisse, Degas and Monet — were also affected by poor eyesight.

CONCLUSION

Although the laurels in medical history will always be to the physicians and scientists, great contributions are made by

the patients who play a central role in the advances in medicine. We should remember this gratefully. □

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Brompton Mixture and Pain

J. F. Filbee,* M.B., F.R.C.P.(C),

Halifax, N.S.

Pulmonary tuberculosis can produce a painful and intractable terminal cough. The staff of Brompton Hospital in London developed a formula for this which is still perhaps the best means we have today for the relief of intractable pain. The original formula was:

Rx	Laudanum	Minims vii
	Cocaine HCl	Gr. 1/6
	Gin	Drachms i
	Honey	Drachms i
	Tinct. of orange	gtt. iii
	Aqua chloroformis	ad ozs i
	Sig.	oz i q4h

Laudanum, the pain reliever, is 1% tincture of opium, and the patient will progressively need more as his system becomes more adept at detoxicating morphine. The mixture can be strengthened by replacing some of the water, without increasing the volume. Cocaine offsets the sedative action of morphine. Since more than 1/3 gr (20 mg) can be hallucinogenic, the analgesic dosage should not be changed by increasing the volume of basic strength mixture. Gin, honey and orange flavour cover the bitter morphine taste.

CANADIAN DEVELOPMENTS

Dr. B. M. Mount, of the Palliative Care Centre, Montreal General Hospital¹ looked at this mixture and concluded that, as morphine is generally not sedative when used in this way, he could omit the cocaine, making it optional. The sweetener and flavouring can easily be added to the dose after measuring it out. Out they came! He found that morphine

solutions deteriorate rapidly without a preservative. This left:

Rx	Morphine	4 mg (or q.s.)
	Gin	5 mL (the preservative)
	Water to make 15 mL	
	Sig.	15 mL q4h

Morphine by mouth is often nauseating. Chlorpromazine appears to be a specific antagonist to this, and 10 mg can be included in every dose if indicated. As the mixture is so bitter, it should always be given with citrus juice.

The half life of this is about 2 1/2 hours, so the full analgesic effect will only be reached after several doses, and the night dose should never be left out. "Prn" orders for Brompton Mixture betray lack of understanding of the medication and should never be used.

EFFECTS AND WITHDRAWAL

If the morphine dose is correct, the patient will be alert, free from pain and from the memory of pain. When he loses his pain, he can abandon his medicine without withdrawal symptoms. Morphine taken for pain does not addict, and here are two patients who benefitted from the mixture and did not become addicted. W. J. P. took morphine for six months after a gunshot wound of the shoulder. When healed, he stopped it without difficulty. R. L. took Brompton mixture for 5 1/2 months for recurrent carcinoma of colon. After a tractotomy this summer he discontinued his mixture with no problem. □

References

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*Radiation Oncologist, Halifax Infirmary, Halifax, N.S.

PROCEEDINGS OF

15th MEETING OF COUNCIL

and

126th ANNUAL MEETING

November 15 - 16, 1979

INTRODUCTION: The 15th Meeting of Council began as the Medical Society Officers accompanied by Dr. R. G. Wilson, Secretary General of The Canadian Medical Association, paraded through Council Chambers to the head table. Following call to order by Dr. M. A. Smith, Chairman of the Executive Committee and General Council, the Officers were introduced and Dr. Wilson brought greetings from The Canadian Medical Association. Dr. Wilson wished Council well in its deliberations and indicated that he would be available to participate in the meeting as required, as would Dr. D. L. Wilson, President of The Canadian Medical Association, upon his arrival later in the morning.

Dr. Smith welcomed the Exhibitors and recognized their contribution to the Annual Meeting. He encouraged Council members to visit the displays and discuss the products and services with the representatives. Dr. Smith extended the Medical Society's invitation to the representatives to attend the Banquet and Ball on Friday evening.

Council began as Mr. D. D. Peacocke, Executive Secretary, read the names of Society members deceased since October 1, 1978 as follows: Dr. Harold B. Atlee of Halifax; Dr. James R. Brown of Dartmouth; Dr. Basil K. Coady of Halifax; Dr. Howard A. Creighton of Lunenburg; Dr. John C. Crosbie of Kentville; Dr. Bogdan Erjavec of Weymouth; Dr. Charles G. Harries of New Glasgow; Dr. James A. Langille of Amherst; Dr. James W. Lewis of River John; Dr. Kailash C. Mathur of New Glasgow; Dr. Provat K. Mookherjee of Amherst; Dr. Walter C. MacKenzie of Edmonton, Alberta; Dr. James R. MacLellan of Sydney; Dr. Wm. M. MacRae of Halifax; and Dr. Vennavally R. Rao of Halifax.

The Transactions of the 14th Meeting of Council and the 125th Annual Meeting (1978) as printed in the December 1978 issue of The Nova Scotia Medical Bulletin were approved.

ARCHIVES COMMITTEE REPORT: This report was presented by the Chairman, Dr. E. F. Ross and received for information. In speaking to his report, Dr. Ross outlined the events of the meeting between himself, Dr. Steele and Mr. Peacocke which had taken place since the report had been written. He noted that it had been agreed that a corresponding member of each Branch Society would be appointed to collect archival material in his/her area.

Dr. C.B. Stewart informed Council that he had brought with him a picture of the Members of Council 1953 for purposes of ascertaining the names of those present before turning it over to the Archives Committee. He suggested that Council 1979 might like to have their picture taken to appear in the Archives 25 years hence; especially with this being the year of the Society's first female President. In concluding his remarks, Dr. Stewart expressed the hope that Dalhousie University would see fit to find space to accommodate Medical Archives in the Sir Charles Tupper Medical Building for ease of reference for medical students.

BY-LAWS COMMITTEE REPORT: The Chairman, Dr. A. H. Parsons presented this report which was received for information.

His recommendation "THAT Section 9.2.1. (n) be amended to read: "To increase general practitioner representation on Council representatives as follows: From each Branch having 50 members or less in good standing in the Society, one member; and for each fifty over the first or fraction thereof, one additional member provided that no Branch shall have the right to nominate more than three general practitioner representatives" was approved.

Dr. Parsons thanked the Society for having had the opportunity of serving as Chairman of this committee for the past three years.

CANCER COMMITTEE REPORT: Dr. A. F. Pyesmany, Chairman, reported that his committee had met on several occasions simultaneously with the Medical Advisory Committee of the Nova Scotia Division of The Canadian Cancer Society. His information report informed the Society that a major and important follow up of the work of the Nova Scotia Oncology Planning Committee was a recommendation for the formation of the Nova Scotia Cancer Treatment and Research Foundation which will co-ordinate cancer care and research for the entire Province. He noted that the Board will include representation from The Medical Society of Nova Scotia.

CHILD HEALTH COMMITTEE REPORT: See Section for Paediatrics.

COMMUNICATIONS ADVISORY COMMITTEE REPORT: Dr. A. J. MacLeod, Chairman, reported that the committee had given consideration to long-term communications problems which might affect the Society in the future. The members contemplated possible courses of action which might be followed relative to long-term public relations matters.

His report indicated that the day-to-day communications matters were dealt with well by the Society office in close co-operation and in support of the Society Officers and President.

Dr. MacLeod encouraged input from all members in various elements of the Society.

COMMUNITY HEALTH COMMITTEE REPORT: Dr. R.D. Stuart in tendering his resignation after three years of active and productive service commented in his report that his committee proposals that the Society develop a birth, pre-school, health record and development chart had been received with limited interest. He noted that the recent issue of The Canadian Medical Association Journal carried a detailed proposal along similar lines.

Dr. Stuart indicated that in his committee's opinion the subject of the Nuclear Industry and all its ramifications would be an important matter to be considered by the Society in the early future.

Dr. Stuart thanked those individuals who had been of assistance to him during his three years as chairman of this committee.

DISCIPLINE COMMITTEE REPORT: Dr. Steele, Chairman, informed the meeting that the committee had not dealt with any problems in the field of discipline, and that all matters falling within this general area had been referred to the Provincial Medical Board which has the responsibility and authority to deal with disciplinary matters.

DRUG & ALCOHOL ABUSE COMMITTEE REPORT: Dr. N. P. Kenny reported on behalf of the Chairman, Dr. C. W. MacNeil, who had extended his regrets. The report made reference to active co-operation with Nova Scotia Commission on Drug Dependency in several areas — i.e. publication of a manual, "Diagnosis and Treatment of Alcoholism for the Primary Care Physician", preparation of a kit for the physicians who are participating in the "Doctors in Schools" program which is directed to reduction in alcohol use, abuse, and addiction, and preparation of a panel during the Society's Annual Meeting on the subject "Foetal Alcohol Syndrome." Dr. Kenny urged all physicians to attend the upcoming panel and also visit the exhibit booth of the Nova Scotia Commission on Drug Dependency.

EDITORIAL BOARD REPORT: Dr. B. J. S. Grogono, Editor, encouraged all members of the Society to participate to a greater extent in maintaining the Society's Bulletin as a useful and well received Journal. He informed the meeting that the Bulletin had reapplied for inclusion in Index Medicus and in this respect was being surveyed by the granting authority. Council approved his recommendation "THAT financial support be continued for the Bulletin for the following year." Dr. Grogono reported that a deficit of approximately \$2,500. for fiscal year 1980 is anticipated.

ETHICS COMMITTEE REPORT: Dr. R. L. Langdon, Chairman, reported to Council that the bulk of ethical matters coming before the Society had been resolved at either his committee level, the Society office, or within the Provincial Medical Board. He indicated that numerous subjects in the ethical area which used to be under the authority of the Society are now the responsibility of the Provincial Medical Board — e.g. in the area of advertising.

Dr. Langdon announced his retirement having served three years as committee chairman.

EXECUTIVE COMMITTEE CHAIRMAN'S REPORT: This was presented by the Chairman, Dr. M. A. Smith. Actions of the Executive Committee during the past year were endorsed. In presenting this report Dr. Smith reminded Council that this report is a synopsis of the meetings of the Executive Committee during the past year. He informed Council that these meetings had been well attended, and all in all the Executive Committee had enjoyed a good year. He noted that the last meeting of the Executive Committee had not been reported on as it had occurred after publication of the Reports to Council.

Dr. Smith drew the attention of Council to paragraph AR32, "The subject of highway safety generally and seat belt legislation specifically was discussed, and it was felt that the Government was dragging its feet on the proclamation of compulsory seat belt legislation. It was moved and carried that The Medical Society of Nova Scotia representative appointed to the Government "Minister's Committee on Highway Safety" be instructed to resign from the committee if seat belt legislation is not proclaimed within six months of this date." He added that the six months was up at about the same time as the December 8th Executive Committee Meeting at which time this matter would be discussed.

The Chairman reported that the Executive Committee had struck an Ad Hoc Committee on Committees to consider in advance of the December 8th meeting the appointment of Chairmen of committees and representatives to various organizations. In the past this matter had been dealt with rather superficially and the Society is now reaping the effects in the form of less than adequate committee activity and reports.

Dr. Smith reported that approximately a dozen members had been written off for non-payment of Medical Society dues. He encouraged all members to make prompt payment of Society dues to reduce operating costs (arising from reminder notices) to a bare minimum.

Dr. Hamm raised the issue of relationships between physicians and hospital boards and pointed to the importance of there being close co-operation between the two. He stated that an excellent means of achieving this is through physician representation on hospital boards and the Society should encourage this as much as possible.

Some members raised their concern at the poor turn-out at Council this year as compared to previous years. It was indicated that the Medical Society would have to make increasing efforts toward encouraging members to become more involved in Society activities.

FINANCE COMMITTEE REPORT: Dr. P. D. Jackson, Chairman, presented the Financial Statements for fiscal year 1979 which ended September 30, 1979. Council approved his recommendations: "That the Financial Statements of The Medical Society of Nova Scotia for the Fiscal Year ending 1979 be approved", and "THAT H. R. Doane and Company be retained as The Medical Society of Nova Scotia auditors for the year 1980."

Dr. Jackson reported that the Executive Committee had approved an increase in the Honorarium from \$50.00 to \$75.00 per day, and that the Schedule of Payment was amended to eliminate the upper limit of days payable.

Dr. Jackson addressed the matter of rising costs and expanding programs and activities of the Society, following which Council approved his recommendation "THAT dues for regular members for Fiscal Year 1981 be increased by \$27.00 and that dues for other categories of membership be increased proportionately."

The treasurer reported that study had been given to establishing a membership dues category of Salaried Physicians. He indicated that a number of doctors gave as their reason for not joining the Society the failure of the Society to provide an appropriate level of dues for physicians who are unable to claim the payment as an income tax deduction. Dr. Jackson said that although many salaried physicians do in fact claim and receive this taxation benefit, there are still some that don't. The committee therefore submitted the following resolution "THAT the Medical Society establish a membership dues category of "Salaried Physicians", defined as a Salaried Physician who pays Medical Society dues personally, is not reimbursed, and is not able to claim the dues payment as an income tax deduction; and THAT the dues for Salaried Physicians be 66 2/3% of the Regular Members' dues for both Medical Society and The Canadian Medical Association" and this was approved.

HOSPITALS COMMITTEE REPORT: The Chairman, Dr. W. G. Dixon, reported that his committee had been quite active during the year and involved in discussions with the Department of Health and the Association of Health Organizations. A particular problem being given consideration is Hospital By-Laws. He informed the meeting that the Rozovsky Prototype By-Laws have no official standing whatsoever and that the Minister has indicated a receptiveness to a suggestion that Guidelines acceptable to both the medical profession and the Association of Health Organizations might be adopted by the Department of Health. Dr. Dixon indicated his committee would be working on this matter in the coming year. Once again, the information arose that in those cases where there were no physicians on hospital boards, problems, sometimes quite serious, often developed. Dr. Steele reported that at a meeting with the Association of Health Organizations (which is the old Hospital Association), the Association was appreciative of the pros and cons of physician representation on hospital boards and had given the Society every indication they were prepared to support such a proposal by the Society. It was reported that further meetings between the Association of Health Organizations and the Society to discuss a variety of mutual problems and matters of interest are being arranged. Dr. Steele expressed the opinion that it is clear that the two organizations have much in common and could well be supportive of one another.

Dr. Dixon reported that his committee had reviewed the Ontario Medical Association Guidelines for the Organization of Chronic Care Units in Acute Care Hospitals and that he would be communicating

with the Executive Committee on this subject at a later date. He expressed the hope that any adoption of similar Guidelines would be in the context of Guidelines only and not Policy Directives.

MATERNAL & PERINATAL HEALTH COMMITTEE REPORT: Dr. R. H. Lea, Chairman, provided the Society with a comprehensive review of activities relating to the Provincial Reproductive Care Program. Also presented to the Society were tables relating to Perinatal Mortality (available at the Society office for interested parties).

Dr. Lea's report indicated that only a small proportion of women took advantage of prenatal care or classes early enough to affect the outcome. Discussion on this subject was extensive and resulted in passing of a resolution "THAT this Council supports the concept of proper funding to guarantee proper facilities for Prenatal Classes throughout the Province, AND to include proper training for public health nurses."

MEDIATION COMMITTEE REPORT: Dr. B. J. Steele, Chairman, expressed concern with the fact that the number of complaints requiring mediation continues at the level for years past. He encouraged all physicians to give the matter of doctor/patient relationships special attention as the image of the profession depends greatly on individual instances which seem often to be maximized and have an effect far greater than their individual importance. He expressed appreciation to the Branch Presidents who have participated in mediating complaints on the Society's behalf.

MEDICAL EDUCATION COMMITTEE REPORT: The Chairman, Dr. M. S. McQuigge, reported increasing interest and involvement in all continuing medical education activities. Regarding Regional Councils, he stated his committee had reviewed this and agreed with the decision made a year ago that in Nova Scotia with a single medical school serving several provinces, the need for a Regional Council is redundant.

On the subject of Mandatory Continuing Medical Education referred to in his report along with the note that C.M.A. General Council has resolved that Continuing Medical Education not be mandatory resulted in extensive discussion. It appears clear that there is no adequate means of evaluating a physician in his practice, or determining precisely the effects of Continuing Medical Education. Dr. Putnam informed Council that his Division of Continuing Medical Education is not in favour of Mandatory C.M.E., but is interested in providing high quality continuing Medical Education programs to all physicians. In conclusion, Dr. McQuigge informed Council that there have been no overtures in Canada by any governments relative to the issue of Mandatory C.M.E.

MEMBERSHIP SERVICES COMMITTEE REPORT: Dr. D. R. MacLean, Chairman, reported that his Committee had spent a great deal of effort on the subject of consideration of transfer of the Society's Insurance Program or portions of it to the Ontario Medical Association. Council approved his recommendation "THAT The Medical Society of Nova Scotia transfer its Long Term Disability, Business Expense Protection and Accidental Death and Dismemberment insurance coverage to the Ontario Medical Association Program of Insurance AND THAT the Medical Society retain our Franchised Group Level Term Life Insurance Plan."

Dr. MacLean also reported that his Committee was giving consideration to other programs which might be of value to Society members and that as these were developed they would be put forward for consideration.

NUTRITION COMMITTEE REPORT: Referred to the Executive Committee.

OCCUPATIONAL MEDICINE COMMITTEE REPORT: Dr. M. R. Rajani presented this report on behalf of the Chairman Dr. A. Prossin.

The Medical Society approved three resolutions as follows: "THAT initiatives be taken by The Medical Society of Nova Scotia to encourage the development of a comprehensive program for the

rehabilitation of injured employees back to a role in society. This is a fundamental ingredient in Occupational Medicine." "THAT The Medical Society of Nova Scotia meet soon with the office of the Dean of Medicine in order to discuss the development of more educational in-put in Occupational Medicine and Occupational Health into the present curriculum for medical students and beyond.", and "THAT The Medical Society of Nova Scotia take leadership in actively pursuing a program which would facilitate the development of medical and occupational health programs for the many small industries in Nova Scotia."

PHARMACY COMMITTEE REPORT: Dr. G. C. Jollymore, Chairman, reported an active year for his committee with discussion centering around the introduction of Supplementary Information on Medications (SIM's). His committee will continue to monitor this project because of the serious implications its introduction could have. Also discussed was the subject of Product Selection. He reported that the committee agrees with the concept of Product Selection only if directions to do so are provided by the physician on his prescription. Council approved the following recommendations: "THAT The Medical Society of Nova Scotia adopt the concept of Product Selection (Substitution) at the indicated direction of the prescriber.", "THAT to facilitate the indication of Product Selection it is recommended that the words 'Product Selection' be inserted on the official Society prescription pads.", and "THAT further discussions are necessary before adoption of the SIM Program takes place."

PHYSICAL FITNESS COMMITTEE REPORT: Dr. B. R. Wheeler, Chairman, reported that the Brief on Physical Fitness Programming in Schools was being reviewed as requested by the Society and would be resubmitted in due course. He added that his committee had been active with other organizations in fitness activities.

Council approved his recommendation "THAT the Grants for Skiing and Orienteering in the amount of \$500.00 each continue."

PRESIDENT'S REPORT: Dr. B. J. Steele reported to Council on activities of the Society, in particular the President's office, not detailed in the Report of the Executive Committee Chairman. He pointed to the Society's open attitude and approach to the news media, and that it appears this is being productive as the media appear to be improving relative to their understanding of medical profession economic circumstances. He reported that relations with the media people are generally good due to the profession's openness, co-operative attitude and availability.

Dr. Steele reported good relations with government, noting that a meeting had been held with the Minister of Health and new Chairman of the Health Services and Insurance Commission, Dr. Michael Laffin, with the result that the Society has expectations that 1980 negotiations on all matters will be conducted in an atmosphere of co-operation and genuine desire to reach mutually acceptable decisions.

In his report Dr. Steele informed the meeting that the Medical Society will be presenting a Brief to Justice Emmett Hall who has been mandated to undertake a review of Canadian Health Insurance Programs. At this point the subject of recognition of Medicare as an Insurance Program was raised with Dr. Steele who encouraged all physicians to acquaint their patients with the fact that it is an Insurance Program of the Government which pays only a portion of the fee, the patient being accountable for the balance of the fee when deemed appropriate by the physician — i.e. taking into consideration Medical Society policy relative to Billing Above Tariff. At this point it was approved by Council "THAT the Billing Above Tariff Policy Statement of September 1979 be reaffirmed at that meeting and that it be so publicized."

Dr. Steele paid tribute to the doctors who have served on the Society's Economics Committee and in particular Dr. Bill Mason who had served as Chairman for two years, and Dr. Merv Shaw who has recently assumed chairmanship of the Committee. He reminded Council of the difficult chore these doctors face on behalf of all members, and urged all members to co-operate and assist the Economics Committee whenever possible.

Dr. Steele then asked Dr. Shaw to speak on the subject of the activities of the Economics Committee. Dr. Shaw provided Council with a resume of the current negotiations and reiterated Dr. Steele's encouragement to all members to support the Society in its endeavors to achieve fair and reasonable settlements. Dr. Shaw also paid tribute to Dr. Mason and the other members of his committee and Society for their tremendous effort on behalf of the Society.

REHABILITATION COMMITTEE REPORT: Dr. G. J. H. Colwell, Chairman, in his report dealt first with the subject of medical profession relationships with physiotherapists. This generated a fair amount of discussion with the feeling being expressed that a principal reason for physiotherapists wanting to go out on their own could be because they are not getting proper direction from the medical profession, and that the medical profession does not have the proper training to give this direction. Dr. Colwell stated this was the reason for his resolution reading "THAT The Medical Society of Nova Scotia continue to maintain good communications with practicing physiotherapists in Nova Scotia and representatives of the Nova Scotia College of Physiotherapists in order to maintain a good working relationship with physiotherapists and to be aware of any further development which could require further action" which was approved. Council then passed the following resolution "THAT this Council expresses concern and interest in furthering Continuing Medical Education and Undergraduate Programs to guide doctors in the use of physical medicine and direction of physiotherapy departments in the treatment of their patients."

The Rehabilitation Committee's second resolution "THAT the Society communicate with the appropriate representatives of Provincial Government to discuss the scope and extent of certain social and health coverage including long-term active treatment beds, prosthetic appliances, sheltered employment, financing of programmes for cardiac rehabilitation, and modification of present regulations governing family benefits." was referred to the Executive Committee for consideration in relation particularly to the use of specific terms to describe hospital beds.

SALARIED PHYSICIANS COMMITTEE REPORT: Dr. J. H. Cooper, Chairman, received approval from Council that a census be taken of all Salaried Physicians groups in Nova Scotia and of the extent of Society membership within each group to facilitate negotiations as well as provision of membership services.

Dr. Cooper's committee also proposed that the Society initiate a program to gather information on unionization in order to have a better understanding of the ramifications. This resulted in considerable discussion with varying points of view being expressed regarding its appropriateness for the medical profession. Following discussion the resolution was referred to the Salaried Physicians Committee for rephrasing and resubmission.

SOCIETY/FACULTY OF MEDICINE LIAISON COMMITTEE REPORT: Dr. Steele, Chairman, reported that the Society and Faculty of Medicine continue to meet on an informal basis and that the exchange of information is most useful as it keeps each organization better informed as to the activities of the other — an example quoted by Dr. Steele is in the field of physician manpower planning.

WORKERS' COMPENSATION BOARD LIAISON COMMITTEE REPORT: Dr. P. Kent Cadegan, Chairman, reported that his committee had participated in presenting a Brief to the Select Committee of Inquiry Into the Workers' Compensation Act. The Brief dealt principally with access by an appellant at an Appeal Hearing to his complete file, rehabilitation, and the basic concept of the Workers' Compensation Program. He indicated the Brief was well received and it appeared that there will be further discussions with the Society on this very important subject.

Council approved a resolution "THAT The Medical Society of Nova Scotia urge the Workers' Compensation Board to assume greater responsibility in rehabilitation programs and try to establish sheltered workshop areas, where injured (disabled) employees may be gainfully employed temporarily."

EXECUTIVE SECRETARY'S REPORT: Mr. Peacocke in presenting his report for information highlighted the subject of public relations and the office involvement in these matters. He also pointed to the need for employees of the Society and physicians to be carefully trained and tutored in the subject of contact with the public. He suggested that it was at this point that serious doctor/patient relationships could originate. He stated that the Medical Society staff take particular pains to present a co-operative and positive attitude whenever approached by the public.

MSNS REP. TO C. M. A. BOARD OF DIRECTORS REPORT: Dr. G. C. Jollymore provided Council with a brief resume of activities of the C. M. A. Board. Principal levels of concern at C. M. A. level are in the areas of physician manpower planning, public relations, and protection of the profession against discriminatory legislation by the Federal Government. He said that the C. M. A. had been actively involved in supporting Prince Edward Island in its recent time of problems.

MSNS REP. TO C. M. A. COUNCIL ON HEALTH CARE REPORT: Dr. M. A. Smith informed Council that this Council was an amalgamation of the C. M. A. Community Health Council and the Medical Services Council. He noted that Dr. Bennett has been appointed Chairman of a sub-committee on environmental health and that Nova Scotia had been asked to name a member to the committee.

MSNS REP. TO C. M. A. COUNCIL OF MEDICAL ECONOMICS REPORT: Dr. A. H. Patterson in his report to Council summarized the work of his Council in supporting the economic goals of C. M. A. members. His report described a number of long term studies being carried out by sub-committees of his Council.

MSNS REP. TO C. M. A. COUNCIL ON MEDICAL EDUCATION REPORT: Dr. J. D. A. Henshaw reported that his Council was involved in a wide range of subjects relating to medical education — e.g. C. M. A. relationship to allied health professions, accreditation of Canadian Medical Schools, to name two of the more important ones. He indicated that a clinical clerkship survey is seeking information regarding the activities and learning patterns of clinical clerks. From this information, it is expected that the larger question of the content and duration of the internship may be addressed.

MSNS REP. TO M. D. MANAGEMENT LIMITED REPORT: Dr. L. A. Fried outlined for Council the range of activities in which M. D. Management is involved. He pointed to the high success rate of M. D. Management programs and the large gains achieved in spite of the opposite trend in the general market.

REPORTS OF REPRESENTATIVES TO OTHER ORGANIZATIONS

MSNS REP. TO COMMUNICABLE DISEASE CONTROL ADVISORY COMMITTEE REPORT: Dr. M. E. Churchill presented her report noting the considerable time spent on development of immunization schedules, and making arrangements for provision of M. M. R. vaccine to physicians in their offices. Council voted a motion of support to the Society and individuals involved for their efforts in achieving this arrangement.

MSNS REP. TO MINISTER'S COMMITTEE ON HIGHWAY SAFETY REPORT: Dr. R. A. Perry presented Council with a most comprehensive report on the work of the committee during the past year. Debate on the point of introduction of legislation to require the use of seat belts was extensive. The suggestion raised was that users of seat belts receive preferential treatment from insurance companies. Dr. Perry suggested that it was not up to the insurance companies to make these decisions; however, he did point out that recently in England a settlement in an accident case had been reduced by 25 percent because in the opinion of the judge the injuries incurred would have been somewhat less severe if the defendant had been wearing a seat belt. The inference of his comment was that this could be precedent setting, and in itself offer an encouragement to the public to take advantage of an obvious means of reducing morbidity and mortality in the event of an automobile accident. Council agreed to a suggestion that the

President encourage all members to personally contact their MLA's regarding this matter. Mr. Peacocke noted that the Minister of Health had recently mentioned to him that the Government has received stacks of letters against mandatory use of seat belts as opposed to scarcely any in favour.

Council approved Dr. Perry's recommendation that The Medical Society of Nova Scotia launch a Public Relations campaign in order to make the public more aware of the necessity for mandatory seat belt legislation, after lengthy discussion as to what form this campaign should take and what it might cost.

During presentation of the report other safety problems arose. Dr. Shaw expressed concern regarding huge trucks travelling at high and excessive speeds. He expressed the opinion that trucks appeared to be involved in a very high number of highway accidents.

Also discussed was the subject of physicians being required to take blood alcohol samples. The validity of the consent was questionable, particularly when the individual more often than not would be impaired. While appreciating the necessity for acquiring blood alcohol samples, physicians were cautioned against hasty action in this regard.

Dr. Perry, in his report, referred to more concerted efforts in some provinces to remove problem drinking drivers from the highways and to institute programs of driver rehabilitation. Council approved his recommendation THAT The Medical Society of Nova Scotia go on record as supporting the introduction of an Impaired Drivers Rehabilitation Program.

MSNS REP. TO JOINT LABORATORY SERVICES COMMITTEE REPORT: Referred to Executive Committee.

MARITIME MEDICAL CARE INC. — PRESIDENT'S REPORT: Dr. A. W. Titus presented M. M. C.'s report on behalf of Dr. E. George Whitman who was unable to be present. The report addressed itself to various subjects such as growth of the private side, its role in administration of M.S.I., and major alterations to the Board structure, the latter receiving considerable discussion during the Fall Branch Meetings. Reference was made to the point that administrative costs of M.S.I. had been reduced from 4.4 to 3.9%. Dr. Titus indicated that this was largely through Government cost-cutting programs and deletion of projects that M. M. C. had been encouraging — e.g. updating the master file.

MSNS REP. TO MEDICAL ADVISORY COMMITTEE ON DRIVER LICENSING REPORT: Referred to the Executive Committee.

MSNS REP. TO NOVA SCOTIA SAFETY COUNCIL REPORT: Dr. G. A. Lawrence's report described for Council the wide range of activities in which this Council was involved — e.g. Training Programs for Driving Instructors, Drug Disposal Programs, Safety Factors relative to Operation of Motorcycles, Consideration of Ambulance Drivers' Qualifications and Skills.

MSNS REP. TO NOVA SCOTIA LUNG ASSOCIATION REPORT: Dr. R. T. Michael reported to Council on the activities of the Lung Association in which he, as Medical Society representative, is involved; these included such items as Continuing Medical Education, Public Education, the Easy Breathers Club, Family Asthma Programs, and working with the Respiratory Interest Group which is an interdisciplinary group of health professionals engaged in the treatment and management of respiratory diseases.

MSNS REP. TO NURSING LIAISON COMMITTEE REPORT: Referred to the Executive Committee.

MSNS REP. TO PHARMACY REVIEW COMMITTEE REPORT: Referred to the Executive Committee.

MSNS REP. TO PHYSICIAN MANPOWER SUBCOMMITTEE REPORT: Dr. A. J. MacLeod reported that the committee had met a number of times during the year and gave consideration to community problems relative to availability of physicians, resident training programs and establishments, immigration of foreign medical graduates. He pointed to the important role this committee would perform in the years ahead as continuing economic pressures were applied to reduce training programs.

MSNS REP. TO PROVINCIAL MEDICAL BOARD REPORT: Referred to the Executive Committee.

RH COMMITTEE DIRECTOR'S REPORT: Referred to the Executive Committee.

REHABILITATION COMMITTEE FOR PHYSICIANS — JOINT MSNS/PMB REPORT: Referred to the Executive Committee.

MSNS REP. TO ST. JOHN AMBULANCE ASSOCIATION — PROVINCIAL ADVISORY COMMITTEE REPORT: Dr. Gillian Lawrence reported in detail on the wide range of activities of St. John Ambulance Association of Nova Scotia including, Training Programs in First Aid, Home Nursing, Safety Oriented First Aid, and C.P.R. Her report described the training programs and also provided an insight with future programs and activities of the St. John Ambulance Association. Her report included statistics which supported the role of St. John Ambulance and their program for provision of first aid. Dr. Lawrence suggested that the efforts of the St. John Ambulance deserve commendation of the Medical Society.

MSNS REP. TO V.O.N. HOME CARE PROGRAM REPORT: Referred to the Executive Committee.

DRUGS & THERAPEUTICS COMMITTEE (FORMULARY COMMITTEE) REPORT: Referred to the Executive Committee.

SECTION CHAIRMEN REPORTS

SECTION FOR ANAESTHESIA REPORT: Referred to the Executive Committee.

SECTION FOR GENERAL PRACTICE REPORT: Dr. D. R. MacLean, in his report, addressed the problem of inactivity within the Section and of the importance of the Section for General Practice being very heavily involved in Society affairs. Dr. MacLean sought suggestions on ways and means of revitalizing the Section, and a suggestion was put forward that the General Practitioners of Canada should be represented at national level, like all other specialties and sub-specialties. Dr. Phillips indicated that the problems being experienced in Nova Scotia in this regard are identical to those being experienced in Ontario. Dr. MacLean's resolution "THAT the Executive Committee of The Medical Society of Nova Scotia review the present organizational structure of the Section of General Practice with the Executive of this Section to determine how the Section of General Practice can become a much more effective and worthwhile body within the Medical Society of Nova Scotia" was approved by Council.

SECTION FOR INTERNAL MEDICINE REPORT: Dr. John W. Stewart presented the Section for Internal Medicine Report as Dr. R. N. Anderson was absent from Canada on business. The report dealt with a brief description of the principal activities of the Section during the year, this being in the area of educational programs. The report also referred to the comprehensive submission on fees made to the Economics Committee by the Section.

SECTION FOR INTERNES AND RESIDENTS REPORT: Dr. Bill Sheridan on behalf of the Chairman, Dr. Dan Roberts, expressed the Section's appreciation to the Medical Society for the valuable aid that it had provided in relation to salary negotiations. The opinion was expressed that the Section should involve itself to a greater extent in the problem of physician manpower requirements for the future.

SECTION FOR OBSTETRICS & GYNECOLOGY REPORT: Dr. R. H. Lea reported on behalf of the Section and responded to questions concerning the routine use of ultra sound. Dr. Lea expressed the view that ultra sound should be recognized as a test and utilized, particularly in high risk pregnancy when required.

SECTION FOR PAEDIATRICS REPORT: Dr. N. P. Kenny in presenting her report informed Council that the Section had been successful in completing the revision of the Infant Feeding Guides and these were now available and being distributed from the Department of Health. She appreciated that some of the recommendations in the booklets are controversial in nature and expressed the hope that where this is the case that these would be reviewed and altered appropriately.

Dr. Kenny described for Council the current efforts being made to produce a seven-part television series "Family Violence in Nova Scotia" in co-operation with the Medical Society; Dalhousie University Faculty of Medicine, Department of Law; Department of Social Services of the Provincial Government. Dr. Kazimirski received confirmation that special attention would be given in this series to the single mother problem.

SECTION FOR PSYCHIATRY REPORT: Dr. John Barteaux informed Council that his Section had been involved extensively with reviewing the Hospital Act, as well as concerning itself with economic matters. He also noted that membership in the Society continues to be a matter of concern and that all efforts were being made to reduce this problem to a bare minimum. Dr. Barteaux, responding to Dr. Steele's question, said that his Section was reviewing proposed legislation to register psychologists and that before any Bill is presented the Society will have the opportunity to propose appropriate changes to it.

SECTION FOR RADIOLOGY REPORT: Dr. Brian Byrne reported on behalf of Dr. Gordon Jones, informing Council that the Section had been involved extensively with the Provincial Department of Health in investigating and reducing excessive radiation to patients from diagnostic sources. He also reported that they had been working with the Economics Committee in developing appropriate fee changes.

NEW BUSINESS:

SEX EDUCATION and FAMILY LIFE EDUCATION: Council approved a motion introduced by Dr. J. P. Savage on this subject reading as follows: "THAT The Medical Society of Nova Scotia strongly support the concept of Sex Education and Family Life Education in Nova Scotia Schools and write to every school board endorsing adequate and well introduced programs." Elaborating on his reason for putting this motion forth Dr. Savage cited the increasing numbers of pregnancies occurring in those eighteen and under. He stated that these young people are getting themselves into situations that they do not have the maturity or emotional stability to handle. Dr. Savage urged his confreres to become involved in an attempt to alleviate this situation.

MEMBERSHIP IN THE MEDICAL SOCIETY OF NOVA SCOTIA: Dr. Henshaw introduced the following motion on this subject: "THAT future increases in the Schedule of Fees, as negotiated by the Economics Committee of the Society, and using Society time and money, be granted only to paid up members of The Medical Society of Nova Scotia." This topic generated a lengthy

debate on the matter of non-members deriving the benefits received through the time, effort and money of Society members. Discussion included how Society members could get their non-member colleagues to become members, and the various tactics that could be used. A motion to refer this motion to the Executive Committee was defeated.

After further discussion it was the consensus of the meeting that the above resolution was an impractical one and it was defeated.

ANNUAL MEETING: On two occasions during Council the Society was called to order in Session of the Annual Meeting to ratify the actions of Council and to hear the President's Valedictory Address which appears subsequent to these Transactions. Additionally, the membership heard and approved the Report of the Nominating Committee which reads as follows:

Appointment of Branch Representatives to the 1979 Executive Committee: — Antigonish-Guysborough — Dr. R. D. Saxon; Bedford-Sackville — Dr. James Fraser; Cape Breton — Drs. M. R. Rajani & M. A. Mian; Colchester East Hants — Dr. D. G. Dewar; Cumberland — Dr. R. Mcl. Washburn; Dartmouth — Drs. J. W. MacDonald & E. C. Ross; Eastern Shore — Dr. P. D. Muirhead; Halifax — Drs. B. D. Byrne, J. K. Hayes, & J. W. Stewart; Inverness-Victoria — Dr. R. Stokes; Lunenburg-Queens — Dr. M. S. McQuigge; Pictou — Dr. C. H. Felderhoff; Shelburne — Dr. J. U. MacWilliam; Valley — Drs. C. Prakash & G. H. Ross; and Western — Dr. C. W. MacNeil.

The 1979 Nominating Committee Members were approved as follows: Antigonish-Guysborough — Dr. J. E. MacDonell; Bedford-Sackville — Dr. T. Chui; Cape Breton — Drs. G. S. Marsh & L. A. Skinner; Colchester East Hants — Dr. A. C. H. Crowe; Cumberland — Dr. A. Elmik; Dartmouth — Drs. J. W. MacDonald & E. C. Ross; Eastern Shore — Dr. A. C. Marshall; Halifax — Drs. B. D. Byrne, J. K. Hayes & J. W. Stewart; Inverness-Victoria — Dr. C. B. Boucher; Lunenburg-Queens — Dr. G. C. Jollymore; Pictou — Dr. J. G. Forbes; Shelburne — Dr. S. M. Woolf; Valley — Drs. W. L. Phillips & P. D. MacLean; Western - Dr. C. W. MacNeil.

The following nominations were confirmed: President-Elect — Dr. A. J. MacLeod; Chairman, Executive Committee — Dr. M. A. Smith; Vice-Chairman, Executive Committee — Dr. Judy Kazimirski; Treasurer — Dr. W. C. Acker; Honorary Secretary — Dr. P. D. Jackson.

The 126th Annual Meeting of the Medical Society of Nova Scotia adjourned at 4:45 p.m.

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 1979 at the Hotel Nova Scotia.

EXHIBITORS

Allen & Hanburys
Anca Laboratories
Boehringer Ingelheim (Canada) Ltd.
Endo Laboratories
Chas. E. Frosst & Company
Geigy Pharmaceuticals
Glaxo Canada Limited
ICI Pharmaceutical Products
McNeil Labs. (Canada) Ltd.
Millex Laboratories Ltd.

Millex Products Limited
Nova Scotia Commission on Drug Dependency
Ortho Pharmaceutical (Canada) Limited
Pennwalt of Canada Limited
Pfizer Company, Ltd.
A. H. Robins Canada Limited
Roussel (Canada) Limited
Schering Corporation Limited
Syntex Ltd.
Warner Syntex/Chilcott Labs. Company, Ltd.
Winthrop Laboratories

NOTE: Contributions towards the Society's Annual Meeting were received from Frank W. Horner Limited, and Merck Sharp & Dohme.

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 their next encounter.

Presidential Valedictory Address, 1979

Dr. Bernard J. Steele, M.D.,

Halifax, N.S.

For the past year I have had the privilege of serving you as President of the Medical Society of Nova Scotia. I wish to thank you for according me the honor of serving. The dedication and competency of our executive staff, Mr. Peacocke and Mr. Schellinck, ease the burden of office greatly. The Society is fortunate in having the services of these men. In addition, I wish to thank the secretaries who have served so well in our office.

Today, the medical profession is continuously under public scrutiny. Hardly a day passes without some reference in the media to some aspect of the practice of medicine. If it is not the cost of medical care, it is the distribution or quality of care that is being analyzed.

I would like to take a few moments to look at medical care from a positive point of view.

In Nova Scotia we have a doctor/patient ratio of approximately 1 to 550. This is about the fourth best ratio in Canada. We have witnessed doctors going to communities that have never had a resident doctor in their history. Each year more doctors are entering practice than ever before. This, of course, is with a relatively static population.

I suggest that there are few people present in this room who cannot recall the day when patients had to be sent to Montreal, Boston or Toronto to receive special medical treatment. Now, this is a rare event indeed. In all areas of medical care, from obstetrics to rehabilitation, we have the medical personnel and facilities to deliver the highest quality of care.

The medical profession has always been in the forefront in promoting better care and facilities for the people of our province. The Officers and Executive of the Medical Society carry on a continuing dialogue with the Ministry of Health to attempt to provide the best facilities for the provision of optimal medical care. I would like to say that we have had excellent relationships with our present Minister of Health, Dr. Sheehy, and his Deputy, Dr. Miller, during the past year. I wish to thank them and members of their department for their promptness in responding to our requests for meetings and their cooperation.

Great advances have been made in many specialized areas of medical care in recent years. Areas such as organ transplantation have changed radically, the management of kidney disease, for example. We are fortunate that we have a highly developed program to cope with this serious problem in our province. Sophisticated care in cardiology and cardiac surgery is available to our people in the province without the necessity to travel a great distance to obtain these services. The same care in paediatrics, plastic, orthopaedic, general surgery, and urology, as well as gynecology, is available within Nova Scotia. Great progress has been made in obstetrical care and neonatology in recent years. The recent addition of a modern rehabilitation unit has attracted the presence of several skilled specialists in this field to Nova Scotia.

These achievements could not be obtained without the expertise of doctors working in our institutions. The recruitment and training of doctors to maintain and enlarge sophisticated services is a continuing necessity. The provision of a healthy environment to encourage doctors to stay and to return to Nova Scotia to practice is a *sine qua non* for progress in medical care.

The poet, Lovelace, writing from his prison cell several hundred years ago, said "Stone walls do not a prison make." I say to you that bricks and mortars do not a hospital make. The essential ingredient in a hospital is the doctor. It is the doctor who makes the diagnosis, prescribes and operates. It is the doctor who takes the ultimate responsibility for medical care.

Increasingly, we see other groups or institutions seeking to encroach upon or exercise unwarranted control of the practice of medicine, either directly or indirectly. Whether these groups be paramedical or institutional they must be resisted. It has been said that the price of liberty is eternal vigilance. Even in these times of high inflation the price of liberty is unchanged. I suggest to you that the proper citadel for the maintenance of vigilance is your Medical Society. It is through the Society only that the united members of the profession can cope with the forces that would weaken us.

Throughout the years we have had the good fortune to have had members who have given of their abilities and time to serve the Society in many different capacities. I commend all of those who have served so willingly. My appeal is that our members come forward to carry the burden, so that our Society will continue to be the vital force that it must be if we are to be true to our profession and achieve more success in promoting the aims of the Society.

The activities of some hospital boards in the province have given rise to considerable concern in the past year. The fetters that are being applied to unnecessarily restrict the role of doctors are exercising a detrimental influence on the good relationships which should exist between medical staff and management. These confrontations do not bode well for the optimal delivery of medical care. The Society is engaged actively in these areas and hopefully they will be resolved in the best interests of all concerned.

A continuing liaison with the Faculty of Medicine is maintained by a committee of the Society and the Dean. This committee has been useful for both the Society and the University.

A high level of attendance and interest at short courses and other medical educational meetings has been encouraging. This reference to medical education may not seem to be appropriate in my address as President of the Medical Society of Nova Scotia. However, in these times when we hear demands for relicensing and compulsory continuing medical education, I think it should be pointed out that we have, now, a high level of continuing medical education among our members on a voluntary basis. I do not think that

our profession would have to take second place to any other profession in this regard. That this is done voluntarily and often at great cost in terms of time and money should be publicly stated. It is a credit to our profession that our members are so well motivated. The increased knowledge obtained is a direct result in better medical care for our people, and this, of course, is the objective of medical practice.

No valedictory address would be complete without a reference to medical economics. Our Economics Committee has recently met with a new Tariff Committee of the Medical Care Insurance Commission and it is hoped that good communication will be established.

Finally, I wish to appeal to the members here today to continue to support the aims of the Society and to encourage the efforts of the officials of the Society so that they may have a more effective organization.

I think that the Society is most fortunate in having Dr. Margaret Churchill as our next President. I know that she will devote her efforts wholeheartedly in the interests of all our members and I wish her well and I know that she will receive the support of the entire Society.

Thank you. □

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Non-Prescription Sleeping Tablets and their Hazards

Patrick Flynn*, M.D., F.R.C.P.(C), Ph.C. and Susan Opie**, B.Sc. (Pharm),

Halifax, N.S.

Physicians and pharmacists should constantly remind themselves that many OTC (over-the-counter; i.e., no prescription required) products contain potent central nervous system acting drugs. These formulations in tablet or capsule form can affect other systems of the body as well.

One of us (P.F.) became aware of this when a puzzling case of a toxic brain syndrome of obscure etiology was admitted to the Victoria General Hospital in 1977. The patient, a 36 year-old male, was eventually found to have bromide poisoning; and abuse of Bromo Seltzer, which he was using, was considered to be the offending agent. However, it was discovered that Bromo Seltzer has not contained bromides for several years.

Following some astute detective work by an intern, it became clear that the patient had been taking large doses (i.e. 100 tablets about every three days) of Somnex, an OTC sleep aid. At that time Somnex contained per tablet:

ammonium bromide	65 mg
potassium bromide	146.25 mg
sodium bromide	130 mg
acetaminophen	162.5 mg

Somnex has been reformulated by the manufacturer and now contains only an antihistamine, diphenhydramine 25 mg. Diphenhydramine is better known under the trade name Benadryl.

Having had this surprising experience, we looked at all the available OTC sleep aids, nerve tonics, and relaxing and calming agents in order to develop an awareness of what patients are actually ingesting in these products. We present our findings hoping that this information will be of interest to physicians and pharmacists.

For the physician, it is still prudent when taking a medication history, to inquire of each patient what they are purchasing from drug stores without prescriptions. This is particularly useful if the patient's symptomatology is confusing, as patients for several reasons are not inclined to tell their physician about these products. The pharmacist must be increasingly vigilant in realizing that these OTC products have a potential for abuse and that a number of them are frankly dangerous to health. Currently available (1979) OTC sleep aids and ingredients include:

Nervine	ASA 325 mg caffeine 30 mg
Somnex	diphenhydramine 25 mg
Sleepeze	mephenesin 162 mg salicylamide 243 mg
Sedicin	mephenesin 200 mg salicylamide 162 mg

*Associate Professor of Psychiatry, Dalhousie University, Halifax, N.S.

**Pharmacist, Nova Scotia Hospital, Dartmouth, N.S.

Calmex	mephenesin 200 mg salicylamide 150 mg
Compoz	guaicol glyceryl ether 50 mg acetaminophen 25 mg salicylamide 60 mg mephenesin 50 mg

It is important to realize what some of these ingredients might do in situations of overuse or when the quantity consumed must be considered a frank abuse of the product.

DIPHENHYDRAMINE is an H₁ blocking antihistamine. Chronic use of antihistamines constitutes a risk to the central nervous system, and both stimulant and depressant effects have been reported. It has significant anticholinergic activity and a pronounced tendency to induce sedation.¹ More recent concerns include Tardive Dyskinesia, a serious neurological disorder, which has been associated with chronic antihistamine intake, although it is more commonly associated with the long-term use of neuroleptic agents.²

MEPHENESIN is a central-acting muscle relaxant. This propanediol compound is the forerunner of meprobamate (Equanil) and methocarbamol (Robaxin). The amounts of mephenesin contained in the above OTC sleep aids are claimed to be subtherapeutic as a muscle relaxant. Any likely beneficial effects of such agents are probably due to their mild sedative properties. The observed effects after large oral doses include drowsiness, dizziness, headache, blurred vision, weakness, lethargy, ataxia, nystagmus, nausea, vomiting and G.I. distress. Typical withdrawal effects, including seizures, can occur if mephenesin containing compounds are consumed in large quantities and even seizures of the alcohol withdrawal type have been reported.

SALICYLAMIDE is the amide of salicylic acid and, like aspirin, has similar antipyretic, analgesic, and anti-inflammatory effects. The toxic effects are similar to those of aspirin; but respiratory alkalosis and metabolic acidosis, which accompany serious ASA toxicity, are not evident with salicylamide. Death usually follows from respiratory depression.

GUAICOL GLYCERYL ETHER: This is guaiphenesin, related chemically to mephenesin and is sometimes used in cough expectorants. It may have muscle relaxant properties in large doses, but this is unlikely in the subtherapeutic dose found in Compoz.

Recently, bromides have been added to Schedule F, Part 1, of The Food and Drugs Act. The President's Bulletin of the Nova Scotia Pharmaceutical Society, which was mailed on July 14, 1978, requested that all products containing bromides be removed from over-the-counter sales in drug stores in Nova Scotia. Although several months have passed since this request was made, it is possible that some of the old OTC sleep aid formulations containing bromides may still be available on the shelves. A list of these OTC sleep aids and their ingredients is as follows:

Rexall Sleep	homatropine methylbromide 1.25 mg acetaminophen 85 mg salicylamide 130 mg
Sominex (old formula)	ammonium bromide 65 mg potassium bromide 146.25 mg sodium bromide 130 mg acetaminophen 162.5 mg
Nytol	calcium bromolactate 325 mg

The bromide salts found previously in OCT sleep aids rarely cause death in an overdose situation. Large quantities of ingested bromide salts are irritant to the stomach and produce emesis.³ The clinical features associated with bromism include nausea, vomiting, respiratory depression, impaired consciousness, muscular weakness and paralysis.⁴ Continued overuse of bromides leads to symptoms which can include restlessness, disorientation, ocular disturbances, ataxia, hallucinations, delirium, stupor and coma.⁵ Bromide blood levels of 60 mgs/ml or greater can be expected from overuse or abuse of bromide-containing products.

Formulations of OTC sleep aid products in the United States differ from Canadian products. It should also be kept in mind that patients may have access to these U.S. products. A useful reference for the contents of U.S. products is the text: *Clinical Toxicology of Commercial Products*,⁶ or a physician or pharmacist in the province can make a phone call to the Poison Control Centre, at the Izaak Walton Killam Hospital for Children in Halifax (424-6161).

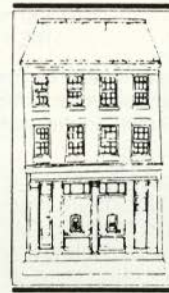
Another area of concern is the incompatibility of OTC products with prescription drugs. For further information on this subject one might consult Hansten's book: *Drug Interactions*.⁷

Pharmaceutical staff working in drug stores, who are aware of a consumer purchasing OTC sleep aids on a regular basis and who may become concerned that the customer is overusing them, should strongly advise of their hazards. Because of possible withdrawal effects, physician consultation should be recommended.

Post Script: You may be interested to know that Bromo Seltzer now (1979) contains an effervescent sodium acetate. Patients on sodium restricted or sodium free diets might not be aware of this source of additional sodium, although the product is so labelled. □

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"INSURANCE — THAT'S ALL!"

An Investigation into the Incidence of Low Back Pain in Horseback Riders

Mary Kernahan*, B.Sc., John Kirpatrick**, B.Sc., and William D. Stanish†, M.D., F.R.C.S.(C),

Halifax, N.S.

Equestrian activities in North America have flourished within the last decade both at the recreational and competitive levels. These activities offer an exciting form of sport and leisure to increasing numbers of people — even the physically disabled. A high degree of skill and a measure of risk are demanded of the competitive rider and understandably, various studies have been undertaken to demonstrate the incidence and scope of horse associated injuries. Barclay¹ simply states that horse-related injuries fall into six main categories: 1) those injuries sustained through falls; 2) those injuries incurred by a crush from the animal; 3) trauma incurred from direct kicks; 4) lacerations from animal bites; 5) rope burns intrinsic to the activity; and 6) wounds from tree branches.

In our area of Canada, horseback riding has gained remarkably increased popularity. In the Nova Scotia Sports Medicine Clinic over the past two years, we have been experiencing an influx of back injuries associated with horseback riding. It was our impression that there existed another potentially serious hazard of riding that is, and was, unrelated to actual injury.

This study was directly triggered by our experience with two young, elite (at the international level) riders who presented to our clinic with marked low back pain. Both these riders had ridden very extensively since childhood and, on further direct functional inquiry, they reported that many of their riding colleagues experienced a similar type of back ache of varying degree and intensity. For this reason a study was undertaken to investigate and report on this clinical phenomenon. Since low back pain was our prime symptom focus the team was, of course, cognizant the multi-faceted nature of this symptom. Thus our rather simple ambition is to report clinical observation concerning horseback riding and back ache in the youthful rider, without concluding cause and effect.

METHODS

As a means of investigation, three of the largest riding academies in our area of Canada were studied — Halifax Junior Bengal Lancers, Pine Ridge Stables and Windgate Stables. Questionnaires were distributed related to the following factors: 1) number of years riding and level of accomplishment; 2) history of competitive and non-competitive jumping and elucidation of the style of riding (English versus Western); 3) the actual length of time per week of riding; and 4) family history of riding. The questionnaire included open areas for discussing the

histories of pre-existing back pain or injuries due to other trauma. We attempted to gather data regarding the details of the pain for complete elucidation and finally, we were interested in the patterns of treatment that had been employed for the back ache in the past.

THE STUDY GROUP

The questionnaire was distributed liberally throughout the three stables to many of the young riders, and 38 young people, aged from 15 to 30 years, returned it. These subjects later attended the Nova Scotia Sports Medicine Clinic for more complete assessment, which included routine radiographs of the thoracic and lumbar spines in the lateral view. From these X-rays underlying pathologic abnormalities were identified with the assistance of our consulting staff in Radiology. Properly endorsed permissions and informed consents were obtained.

The degree of back pain experienced by subjects was classified by the following technique:

Grade 1) Mild pain: pain occurring less than one episode per week of short duration (based on the patient's memory); no palliative measures were employed.

Grade 2) Moderate pain: pain occurring more than twice per week and aggravated or relieved by certain therapeutic techniques initiated by the patient; the patient's activities of daily living were mildly altered by this pain.

Grade 3) Severe pain: pain was very frequent and severe being experienced in other activities than simply during riding; pain severe enough to restrict the riding program and other recreational activities; the back supports were used or contemplated.

Grade 4) Disabling pain: pain as a presenting symptom at the clinic being constant and severe; back support employed; pain restricted and possibly forced the patient to give up riding temporarily or permanently.

RADIOGRAPHIC ASSESSMENT

The predominant radiographic findings were found to be the following three patterns:

1) Varying degrees of endplate scalloping and associated endplate irregularities of vertebral bodies, felt by expert radiographic interpretation to be beyond normal age group magnitude.

2) Spurring both anterior and posterior of the vertebral bodies, with evidence of disc space narrowing against radiographically appraised age group control by expert analyses.

3) Schmorl's nodes; distinct evidence of disc herniation into the vertebral body.

These three patterns were used as a means of classification (Table 1):

*Third year Medical Student, Faculty of Medicine Dalhousie University, Halifax, N.S.

**Second Year Medical Student, Faculty of Medicine Dalhousie University, Halifax, N.S.

†Co-ordinator, Nova Scotia Sport Medicine Clinic, Orthopaedic Surgery, Dalhousie University, Halifax, N.S.

TABLE I

Degenerative Change	Number of Subjects	Mean Age	Mean Years Riding
Scalloping and Endplate Irregularities	8	21.6 years	12.7 years
Spurring	3	20.6 years	12.7 years
Schmorl's nodes	5	19.6 years	10.1 years

These results were from a total of 20 X-rayed subjects and it must be noted that these x-rays were analyzed by an unbiased radiographer and orthopedic surgeon without study bias.

RESULTS

Analysis and Quantitation of Back Pain

Three questionnaires were returned with no history of back pain. The results indicated an association between the intensity of the low back ache and 1) the number of years that the patient had been riding; and 2) the number of hours riding per week. Table II classifies more carefully the low back pain syndrome in horseback riders:

Patterns of the Pain

A question related to the time of pain occurrence showed the following results: 1) Pain during riding hours — 14 subjects; 2) Pain after riding hours — 12 subjects, and 3) Pain continuous during and after riding — 5 subjects.

The number of subjects indicated pain of varying duration occurring after riding. The duration of the pain varied from 15 minutes to days and was continuous in some. The remaining subjects (not included in this classification) neglected to define the type of pain pattern.

Magnitude of Pain

Another interesting feature of this study was the young riders' response to their pain. There was reluctance among the riders to decrease riding time to alleviate the pain even among the more severely involved and affected individuals. This was obvious from the response to the questionnaire category: "Did back pain ever cause you the following: 1) to decrease riding time — number of subjects with positive response — 5; 2) to stop riding entirely — number of subjects with positive response — 3; 3) change your type of riding — one subject with positive response; and 4) limit you in riding as well as other activities — number of subjects with positive response — 4. Twenty-five patients, or 70% of the study

group answered "no" to all of these questions.

The severity of the back ache was really quite obvious and is evidenced in the fact that three subjects had to give up riding entirely including one of Canada's top junior equestrian performers because of the intractable and persistent back ache.

TECHNIQUES OF MANAGEMENT

Of the presenting riders, five had previously used back supports or special equipment when riding, and one other rider was in the process of being fitted with an elastic polo belt. External supports have been noted as serving two useful purposes in the management of a problem back. A lumbosacral orthosis may be used as a test to determine if some type of restraint will lessen back pain; and supports may be employed to reduce the possibilities of an acute back injury.⁴ In the group of the five patients using back supports, it was not recorded whether they showed reduction in symptoms. This group had an average age of 24 years and ranged in riding experience from 13 to 18 years.

DISCUSSION

According to Bodnar² of various injuries to one's back, soft tissues remain the most common type of injury focus in sports and athletes. They may result from overuse, direct trauma to the region or indirect injury, forcing the vertebral joints and their surrounding ligamentous supports beyond their normal range of motion. More severe force can produce injury to the vertebral disc or bony elements.

Low back pain, as a result of wear and tear processes, has been demonstrated fairly conclusively by these results. However, the extreme variation in severity between individuals is worth of comment. The fact that one individual, riding regularly since early childhood, develops significant spine disability while another, equally active, is barely affected, suggests the likelihood of some underlying factors yet undetermined. Indeed the rider's technique and quality of instruction, together with his innate horsemanship ability, may and possibly do act as predisposing factors. It is well known that some people ride naturally in unity with their horse while others never achieve that true balance. The rider's "feet" is something which some persons never master properly. The lack of rhythm involved in such cases, as well as the tension that may accompany it, suggest a definite aggravating mechanism. Tension is not rare among riders and many of our patients readily confessed statements such as, "I was nervous on my new thoroughbred and was always tense when I rode him. That's when I first noticed my back ache..."

TABLE II

Classification of Low Back Pain	Number of Subjects	Mean Age	Mean Yrs. Riding	Mean Range Riding Hours Per Week
0	3			
Mild	11	17.5 yrs	8.6 yrs	7-10 hrs/wk
Moderate	18	21 yrs	11.1 yrs	11-14 hrs/wk
Severe	3	23.3 yrs	17 yrs	15-18 hrs/wk
Disabling	3	21.3 yrs	14 yrs	> 20 hrs/wk

Basic flexibility is postulated to play a large role in the rider's performance. Singleton, in her thesis entitled *The Relationship of Balance, Low Back Flexibility and Ankle Flexibility to Balanced Seat Equitation* (1968), has provided a valuable insight into the question of seat, flexibility and balance as a function of the rider's performance.⁷ Although not concerned specifically with trauma, the author states that the flexible lumbar spine is important to the rider's comfort because it works with the hip and ankle joints to absorb the shock of the horse's movements. Flexibility in this area of the axial skeleton enables the rider's back to "give" with each stride taken by the animal and therefore affords comfortable "seat" on the mount.^{3,8} With most sports, especially those involving finesse, a flexible body is mandatory and riding is certainly no exception in our opinion. Singleton reiterates that a flexible back may possibly be employed as an aid to move the horse faster at various gaits.⁶ Flexibility in the lumbar spine area also makes it possible for the rider to control a horse by using both unilateral and bilateral tightening of the muscles of the back as sideward or forward push for this action is transmitted by the lumbar region.⁵

Singleton has also pointed out the merits of flexibility with regards to decreasing shock absorption of the spine. These facts all favor the incorporation into riding instruction of a stretching program, carefully designed to increase the flexibility. Such a program, consisting of routine flexibility training on and off the mount, may make a significant contribution to curbing a potentially serious adverse effect of this beloved sport. □

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Treatment of steroid-responsive asthma.

1. In asthmatic patients who do not respond adequately to conventional therapy.
2. In steroid-dependent asthmatics where a reduction of systemic steroids is desirable.

Contraindications

1. In status asthmaticus or in patients with moderate to severe bronchiectasis.
2. Active or quiescent untreated pulmonary tuberculosis.
3. Untreated fungal, bacterial or viral infections of the respiratory system.
4. In children under the age of 6 years.

Warnings

1. Glucocorticoids may mask some signs of infection and new infections may appear during its use.
2. "THE DEVELOPMENT OF PHARYNGEAL AND LARYNGEAL CANDIDIASIS IS CAUSE FOR CONCERN BECAUSE THE EXTENT OF ITS PENETRATION OF THE RESPIRATORY TRACT IS UNKNOWN. IF CANDIDIASIS DEVELOPS VANCERIAL SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY INSTITUTED".
3. In patients previously on high doses of systemic steroids, transfer to Vancerial Inhaler may cause withdrawal symptoms: tiredness, aches and pains, and depression. In severe cases, acute adrenal insufficiency may occur necessitating the temporary resumption of systemic steroids.
4. The safety of Vancerial in pregnancy has not been established. If used, the expected benefits should be weighed against the potential hazards to the fetus, particularly during the first trimester of pregnancy.

Precautions

1. The transfer of a patient from systemic steroid to Vancerial Inhaler has to be very gradual and carefully supervised by the physician. The guidelines under Dosage and Administration should be followed.
2. A decreased resistance to localized infection has been observed during corticosteroid therapy.
3. During long-term therapy, pituitary adrenal function and haematological status should be periodically assessed.
4. Fluorocarbon propellants may be hazardous if they are deliberately abused. Inhalation of high concentrations of aerosol sprays has brought about cardiovascular toxic effects and even death, especially under conditions of hypoxia. However, evidence attests to the relative safety of aerosols when used properly and with adequate ventilation.
5. It is essential that the patients be instructed that Vancerial Inhaler is a preventative agent which must be taken at regular intervals, and is not to be used during an asthmatic attack.
6. There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis.
7. Acetylsalicylic acid should be used cautiously in conjunction with corticosteroids in hypoprothrombemia.
8. Patients should be advised to inform subsequent physicians of the prior use of corticosteroids.

Adverse Reactions

No major side effects attributable to the use of recommended doses of Vancerial Inhaler have been reported. No significant systemic effects have been observed when the daily dose was below 1 mg (twenty inhalations). Above this dose, reduction of plasma cortisol, indicating adrenal cortical suppression, may occur. Therapeutic doses may cause the appearance of *Candida albicans* in the mouth and throat. In some patients the appearance of hoarseness or pharyngeal irritation has been observed, occasionally necessitating withdrawal of treatment. The replacement of systemic steroids with Vancerial Inhaler may unmask symptoms of allergies which were previously suppressed by the systemic drug. Conditions such as allergic rhinitis and eczema may thus become apparent during Vancerial therapy after the withdrawal of systemic corticosteroids, and should be treated appropriately.

Symptoms and treatment of overdose

Overdose may cause systemic steroid effects resulting in symptoms of hypocorticism and/or adrenal suppression. Decreasing the dose will abolish some of these side effects, when due to excessive dosage. Adrenal suppression should be treated symptomatically.

Dosage and Administration

Optimum doses vary, but the total daily dose should not exceed 1 mg of beclomethasone dipropionate (20 inhalations), and should not be initiated until the severe attack has been controlled with systemic corticosteroids.

Adults: Two inhalations (each 50 µg) three to four times/day is the usual maintenance dose. In severe cases it is advisable to control the symptoms with systemic corticosteroids before starting treatment with beclomethasone dipropionate inhaler.

Children: Insufficient information is available to warrant the safe use in children under age 6. For children over 6 years of age one inhalation (50 µg) up to four times daily.

MAXIMUM DAILY DOSE SHOULD NOT EXCEED 20 INHALATIONS FOR ADULTS AND 10 INHALATIONS FOR CHILDREN UNDER 12 YEARS OF AGE.

Since the effect of Vancerial Inhaler depends on its regular use and on the proper inhalation technique, patients must be instructed to take inhalations at regular intervals. They should also be instructed in the correct method: to exhale completely, lips to be placed lightly around the mouth-piece and activate the aerosol in the next inspiratory period. In the presence of excess mucus secretion, severe attacks of asthma, and/or infection or high atmospheric concentrations of appropriate antigens, the drug may fail to reach the bronchioles. Therefore, if an obvious response is not obtained after 7 days, appropriate therapy including a short course of systemic corticosteroids should be initiated before returning to the use of inhaler, as well as the concomitant use of a broncho-dilator aerosol.

Careful attention must be given to patients previously treated for prolonged periods with systemic corticosteroids when transferring them to beclomethasone. Initially, Vancerial and the systemic steroid must be given concomitantly for 10-14 days, followed by a gradual withdrawal of the systemic steroids. Dose reductions should be the equivalent of 1.0 mg every 10-14 days if close continuous medical supervision is not feasible. It may be possible to withdraw systemic corticosteroids more rapidly if the initial dosage was 7.5 mg daily of prednisone (or equivalent) or less, or if the patient is under close continuous medical supervision. Some patients may not be able to completely discontinue the use of systemic steroids. In such cases a minimum maintenance dose should be continued in addition to Vancerial Inhaler.

Dosage Form

Vancerial Inhaler is a metered-dose aerosol, delivering 50 µg per inhalation. Each canister provides 200 metered sprays.

Full information is published in the Compendium of Pharmaceuticals and Specialties and available on request from Schering Canada Inc., Pointe Claire, Quebec H9R 1B4.

*Reg. T.M.

PAAB

MEMBER

PMAC

SCHERING

Correspondence

To the Editor:

A few weeks ago the S.I.U. (System of International Units) was introduced by the Pathology Department of the Victoria General Hospital which also reports to some other hospitals. To a number of physicians this was a total surprise, launched with no forwarding and meant considerable inconvenience at the very minimum in sorting out the meaning of the obscure new terms. Further inquiry revealed the offer of a yellow handbook from the Department of Pathology. This enabled one to translate from the old metric to the new system. An introduction to this handbook and a reference provided points out that (1) a committee had considered the system carefully and decided on the switch in order to conform to the majority of world practice and (2) although no particular advantage would be evident in the near future from this arbitrarily imposed switch, some was probable in the distant future.

There are some major objections to this innovation and its manner of introduction. In the first place, the committee that decided on this switch was composed entirely of pathologists and clinical chemists and had no clinicians on it — and certainly no patients. This shows a regrettable lack of consideration towards the consumers and is out of keeping with current responsible practice. Adequate consultation with and representation of clinicians on this committee might have helped to make any changes less inconvenient for the practising physician and therefore less hazardous to the patient — the reason why we in the medical profession are in practice after all. To compound the confusion even this switch is not universal in Halifax — one can receive results in both terminologies thus achieving the need for immediate "bilingualism".

The system is not in general use in the United States — the major scientific community with more impact on Canadian medicine than any other country. For Halifax to ignore the United States is bold and chauvinistic but thoroughly inconvenient to those of us who read the American scientific literature.

In addition, concentrations of substances are expressed in moles or fractions of moles however those of us in clinical practice do not administer medications in moles but in grams (or even in grains) and to report concentrations in a different system is illogical.

M. J. McQueen (Nova Scotia Medical Bulletin 54:135, 1975) writes in an overview of the system that "great care must be taken to educate all those who will be affected by the changeover" and that there should be considerable advance publicity with regards to proposing the changeover. This is precisely what did not take place, contrary to their own advice, and far from the system being universal in Canada or even in Nova Scotia, it is not in practice throughout the whole of Halifax. It really does seem that our pathologists are worshipping at an altar of pseudo science and leaving the clinicians to care for the irritations of their administrative adventure.

I would appreciate the views of others who have to explore this farmyard of metric moles in which one can not see any joules in the eye of the metric code.

Yours sincerely,

"UNREPENTANT"

To the Editor:

I would like to call your attention to the work of Amnesty International, especially with regard to torture.

I would especially like to mention that there exists in Canada a Medical group which has members in different parts of the country. These doctors carry out extensive examinations of people who seek refuge in Canada and who claim to have been tortured. If they find that indeed these people have been ill-treated a report is written to support their application. If you so wish you can get in touch with this group by writing the National Office in Ottawa: 2101 Algonquin Ave., K2A 1T1.

Part of our work in the Campaign for the Abolition of Torture consists of sending telegrams with follow-up letters to offending governments. We have an "Urgent Action" network, coordinated by Dr. Osborg, with whom you can get in touch through the Ottawa Office.

There are a number of reasons why it is important for our organization to have the support of the medical profession. Through resolutions at national and international meetings they can give a high profile to the phenomenon of torture. Psychiatrists are well aware of the fact that psychiatry is abused in countries "behind the iron curtain". They can express solidarity with their colleagues whose very lives are in danger because they refuse to cooperate with a brutal regime and in this way exert international pressure.

At the same time such resolutions challenge doctors who supervise torture and may help to bolster the moral fortitude to refuse to do so in the future. Public exposure of these practices is probably the best way to obtain abolition!

Obviously we look to doctors for financial support as well. Realizing that doctors are often busy and cannot spend a

great deal of time writing letters, they can help others do this work through their financial contributions. At the local levels all the work done is voluntary. For your interest I am sending our annual fundraising letter which has gone to a number of doctors in October.

We would be very glad if doctors who are interested to work with us would call us, so that we could discuss the level of cooperation. It may take the form of writing occasional letters or signing appeals. I will be pleased to give you any further information or clarification by phone or by meeting with you.

Sincerely yours,

Corrie Douma,
Amnesty International

□



Dalplex

The Stairs property on South Street was acquired by Dalhousie in 1970. The "Moseley house" adjoining this site was the old Classics Department — a large number of Latin and Greek texts were rescued from the basement of this building when it was being demolished in 1971, to make way for the future parking lot.

After the demise of Mrs. Staris, her magnificent house was converted to Dalhousie University offices and the surrounding land returned to nature. It became a favourite gardening resort for many Southend Haligonians who enjoyed its succulent raspberries and legumes. The neighbouring field was used as a practice site for Dalhousie athletes.

Delays in construction from several years of controversy increased the price by 5½ million dollars and required an appeal by Dalhousie University to the Supreme Court of Canada on zoning legislation. The total cost was around 10½ million dollars, 6 million of which were supplied by the Province of Nova Scotia, \$200,000 by the Federal Government and the rest by the fund raising campaign "Dalplex", chaired by Stewart McInnes.

The building was designed by Ojar Biskarps for maximum personal active participation as well as the training of future Olympic Champions, and is one of the most innovative in Canada. Facilities include an Olympic pool, a giant field-house for basketball, volleyball, tennis, badminton, track as well as golf and archery ranges, squash and racketball courts. The sixteenth of an inch thick stainless steel roof is supported by air pressure which allows for 50,000 square feet of uninterrupted floor space

Dalplex was officially unveiled on October 19, 1979, by Honorable Henry Hicks, Q.C., President of Dalhousie University. Future plans for an adjoining hockey rink to replace Dalhousie Memorial Rink destroyed by fire in May, 1978, remain in the balance.

Future generations of Nova Scotians will have an outstanding chance to lead the world in athletic prowess. □

B.J.S.G.

Olympian Overture

B. J. S. Grogono,* M.B.,
Halifax, N.S.

*Our Parthenon
stands
gaunt but neatly trimmed
panting like some relentless panther
eyeing her prey.*

*A gargantuan lair
waits
cavernous and bare
beckoning her pilgrims
to taste
to test
her charms.*



*Like Zeus' thunder bolts
they came
horrendous monsters
blasting
mouthing their way
with savage gulps
to leave
their mark of desolation.*



*Out of this craggy mire
She rose
a space age flower
topped by a priceless petal
brazen and bewildered
a unique prize
conceived by man
but fit for the Olympian Gods.*

*Yesterday
a gentler generation
strolled around her home.
Here scholars spelt out strange
tongues
(Caesar and Plato equally enjoined)
Here the unknown athletes spent their zest
(unfettering the wild ambition of their
youth)
Here bloomed wild nectars
(plucked by many a gracious hand)
Here Time dispensed
her all engaging spell of serendipity.*



*Look up with reverence
all who enter here!
Honour the majestic ideals of the past.
Embrace the magic inspiration of true
sport.
Achieve new feats of skill.
Transcend the dreams that soar
Beyond the wildest aspirations of Appollo!* □

*Chief of Orthopaedics, The Halifax Infirmary, Halifax, N.S.
Photographs courtesy Information Office, Dalhousie University.

Pictorial Highlights

126th Annual Meeting



Mrs. Chester Stewart, Dr. Dennis Howell and D. Emerson Moffitt are seen enjoying themselves at the joint Medical Society/Dalhousie Medical Alumni Reception and Buffet.



Dr. Gerald Sheehy, Minister of Health, emphasizing his belief in the value of co-operation, communication and consultation with the medical community.



Dr. W. R. C. Tupper, President of the Dalhousie Medical Alumni Association welcoming Dr. J. B. MacDonald as Honorary President of the Association for 1979-80.



Theresa and Bernie Steele share a moment with Stu and Margie Huestis at the joint Medical Society/Dalhousie Medical Alumni Reception and Buffet.



Members and well wishers watching the presentations at the joint Medical Society/Dalhousie Medical Alumni Reception and Buffet.



Dr. W. R. C. Tupper, President of the Dalhousie Medical Alumni Association welcoming Dr. R. Ian Macdonald as Alumnus of the Year, 1979-80.

Photographs by Kerry DeLory and Audio Visual, Tupper Building.



Delegates to Council 1979 listen intently as Dr. Larry Wilson, C. M. A. President, addresses them.



Dr. Larry Wilson C. M. A. President, in the process of installing Dr. Margaret Churchill of Yarmouth as President of The Medical Society of Nova Scotia. Dr. Steele, about to become immediate Past President looks on.



Yarmouth physicians represented by Dr. Ches Wyman presents bouquet and gift to Dr. Margaret Churchill before her installation as President of The Medical Society of Nova Scotia.



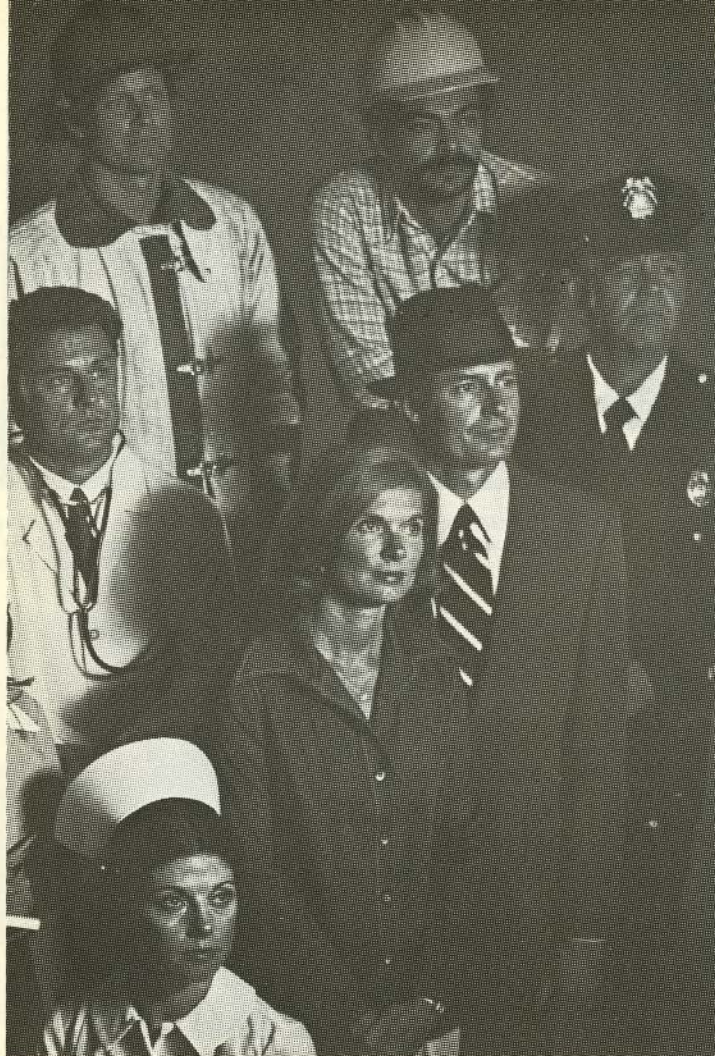
Dr. John Hamm confirms for Theresa Steele that she does deserve the gift for her support of Bernie during his year as President.



Dr. Margaret Churchill, newly installed President, presents Dr. Bernie Steele with his Past President's Pin.



Medical Society members relax during the 1979 Annual Banquet and Ball.



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Personal Interest Notes

SENIOR MEMBERSHIP CITATIONS THE MEDICAL SOCIETY OF NOVA SCOTIA

Dr. Douglas Kerr Murray



Dr. Doug Murray of Halifax receives Senior Membership, Nova Scotia from President Bernie Steele.

Dr. Douglas Kerr Murray was born in Pictou, Nova Scotia, the son of a general practitioner of that town. He attended Pictou Academy and subsequently Mount Allison University for his pre-medical training.

He came to Dalhousie in 1930 and embarked upon an outstanding extra-curricular career. He played for four years on the English rugby team and was on the varsity boxing team as a light-heavyweight for four years. He was also President of the Dalhousie Glee and Choral Club. In the time left over he studied medicine and was graduated in 1935, carrying off two prestigious awards: the Dr. Hogan prize in surgery and the Dr. Miller prize in chest diseases.

His first job was with the government as a medical officer aboard a minesweeper which had been converted to a sort-of-hospital boat and sent to the Grand Banks to attend the men of the fishing schooners. During this time M-G-M studios were filming "Captains Courageous" on the Grand Banks. Once again the ham in Doug Murray came to the fore and he signed on with the film crew. Some scenes were shot in Gloucester and while in New England, he met and married Miss Ruth Skaling of Connecticut.

He was invited to sail around to Hollywood to complete the picture but better judgement prevailed and he returned to Nova Scotia where he established a general practice in Liverpool and stayed fourteen years.

He returned to Dalhousie where he became one of the first residents in ophthalmology. He also trained for four years in Baltimore in the combined specialty of eye, ear, nose and throat. He established practice in Halifax in 1951 and has been active in practice and teaching to the present day. He is currently a consultant in the Department of Ophthalmology. It is well worth noting that Doctor Murray performed the first corneal transplant in Nova Scotia.

The Murray's have four children all of whom are graduates of Dalhousie — Doctor Duncan is a physiatrist and is Chief-of-Staff of the Department of Rehabilitation Medicine at U.B.C. Bonnie is married to Dr. Sany Ross, an eye surgeon in Penticton, B.C. There are twin daughters — Victoria, married to Dr. Ken Wilson, a final-year resident in plastic surgery and Kitty, who strayed from the medical path and married a lawyer. Doctor Murray says his number one hobby is his nine grand-children. Other hobbies in random order are saddle horses, raising sheep in Pictou County and being a long-time elder of St. Matthew's United Church.

Doctor Murray has been active over the years in the affairs of the Medical Society, serving on a variety of committees. In 1973 he was President of the Halifax Medical Society. Perhaps his greatest contribution to his profession is one we hear little about. He has served for a number of years as representative of this Society on the joint Society-P.M.B. Committee for the Rehabilitation of Impaired Physicians. This work is always time-consuming, often frustrating but, as you will appreciate, vital to the medical profession.

You will understand from the foregoing why it gives me great pleasure to present Dr. Douglas Kerr Murray for installation as Senior Member in The Medical Society of Nova Scotia.

Dr. J. Kempton Hayes
President
The Halifax Medical Society

Dr. Wilfred MacIsaac



Dr. Wilfred (Bill) MacIsaac of Margaree Forks receives warm welcome and Senior Membership, Nova Scotia from long time friend Dr. Bernie Steele.

Dr. Wilfred MacIassac was born in Inverness on October 24, 1905. He was educated in the Inverness schools, then attended Xavier University and graduated in 1925. He graduated from Medical School in 1938 and went on to post graduate training in EENT in Saint John, New Brunswick.

In 1940 he joined the Royal Canadian Medical Corps and served during the campaign in Italy. He received a medical discharge in 1944, then continued his post graduate training in Boston (1944 - 1946), returning to Sydney to commence practice in eye, ear, nose and throat. In 1951 he moved to Margaree Forks and purchased the Margaree Lodge which has since become a landmark on the Western Coast of Cape Breton Island. He continued his EENT practice until his retirement in 1972.

During his 28 years in Cape Breton he has been extremely active in Community Affairs and has been a Member and President of various Community organizations. He was particularly well known for his work in the Cape Breton Tourist Association and was a Grand Knight in the Knights of Columbus. Dr. Bill, as he is known to his friends and patients, has continued to contribute to the Island and his Community during his retirement.

Dr. Bill's skill and dedication has been received by his colleagues and patients alike and it is with great pride that we propose him for Senior Membership in the Medical Society of Nova Scotia.

Dr. C. Bernard Maclean
Inverness-Victoria Branch Society

**SENIOR MEMBERSHIP CITATIONS
THE CANADIAN MEDICAL ASSOCIATION**

Dr. James Carson Murray

Doctor James Carson Murray of Springhill, Nova Scotia was born on January 7, 1908 at Tatamagouche, Colchester County, Nova Scotia. He obtained his early schooling there, but completed his Grade 12 at the Pictou Academy. He graduated from Dalhousie University with a Bachelor of Arts in 1928.

He entered Dalhousie Medical School in the fall of 1928 and graduated in 1933. He took post-graduate training in surgery at St. Luke's Hospital, Cleveland, Ohio, and at Camp Hill Hospital, Halifax, N.S. He practised in Tatamagouche in 1933 and 1934. He came to Springhill in July 1935, and remained in active practice in that community until 1977.

He married in 1937, and is the father of six children, all of whom have distinguished themselves in various fields of endeavour — the entertainment world, medicine, and engineering.

Dr. Murray has been a member of the Executive of The Medical Society of Nova Scotia. He was the Chairman of the Board of All Saints' Springhill Hospital, and was the Chief of Staff of that institution for many years. He was Divisional Surgeon of the Saint John Ambulance Brigade from 1953 until 1977. On three occasions he has been the President of



Marion Murray receives on behalf of her husband, Dr. Carson Murray of Springhill, the award of Senior Member, C. M. A.

the Cumberland Branch of the Medical Society of Nova Scotia.

During the Springhill mining disasters of 1956 and 1958, Dr. Murray organized the efforts of the medical teams involved in the care of the dozens of injured miners. His efforts in those difficult times exemplified the highest ideals of the medical profession. Dr. Murray gained an excellent reputation in the field of fracture surgery, largely through his experiences in treating injured miners on a day-to-day basis.

Dr. Murray retired in 1977, but he and Mrs. Murray continue to reside in Springhill.

Dr. William Earl Pollett

Doctor W. Earl Pollett was born in Sydney, Nova Scotia on September 3, 1907, where he received his early education and graduated from Sydney Academy. He received his B.A. from Dalhousie in 1930 and his M.D. in 1934.

Following graduation he did general practice in New Germany, Lunenburg County for three years, and then made the decision to do postgraduate surgical training at Hammersmith Hospital in London. Then Earl spent four years as Resident Surgeon at Gogarham Hospital in Edinburgh, and received his F.R.C.S. (Edin) in 1943. During his years in Britain he was a surgeon in military hospitals at Scapa Flow during the Norwegian campaign; also a surgeon of a mobile surgical unit for air raid casualties — including air raid Blitz of Glasgow; and surgeon to Highlands and Islands of Scotland (Department of Health for Scotland). Also, he was surgeon in charge of the Casualty Clearing Station at Epsom and Basingstoke during and following D. Day. He returned to Canada in 1946 and received his F.R.C.S. (C) in 1947.

Earl practised in Halifax from 1947 to 1977, and soon developed a large practice because of his sympathy, friendly manner, kindness and ability. He joined the part time surgical staff of the Dalhousie Department of Surgery in 1947.

OBITUARY

Dr. Walter J. Payne (70), Sydney, N. S. died on November 22, 1979 at the New Waterford Consolidated Hospital. Dr. Payne was a graduate of Dublin University Medical School and took postgraduate studies in Diagnostic Radiology in London, England. He is survived by his wife Dorothy, two sons and a daughter. Our sympathy is extended to the family. □

He was an Assistant and later Associate Surgeon at the Children's Hospital from 1947 to 1972, and also a member of the Medical Executive of the Children's Hospital for eight years, as well as President of the Medical Staff. In addition, Earl was an associate surgeon at the Victoria General Hospital from 1947 to 1954. He was considered by many of the students as one of the better teachers in the Department of Surgery.

He is a member of the Halifax Medical Society, The Medical Society of Nova Scotia, and The Canadian Medical Association. Earl regularly attended the meetings of the regional medical society, and his comments and words of wisdom were offered with humor and forethought. He was President of the Halifax Medical Society in 1970, and a member of the Executive of The Medical Society of Nova Scotia from 1969 to 1972; also an Associate Editor of the *Nova Scotia Medical Bulletin* for seven years and he has published articles in several medical journals.



Dr. Larry Wilson, President of C. M.A., exchanges private word with Dr. Earl Pollett of Halifax as he is presented with Senior Membership, C. M. A.

Shortly after graduation Earl married Hope Hatfield — a pleasant and gracious lifetime companion. They have three children — their son is an anaesthetist who is married to an anaesthetist; their elder daughter is married to the current vice-chairman of Executive of The Medical Society of Nova Scotia, and their younger daughter is a specialist teacher for handicapped children in Toronto.

He has always had a great interest in the "practice of medicine"; however, his second love is his interest in history. He has often said, "if I had not been a medical doctor, I would have loved to have been a history professor." Earl is an excellent conversationalist and wit.

His courage and his desire to enjoy life is no better exemplified than in the recoveries he made after two very serious illnesses. He is probably the most ardent, but just perhaps, not the best golfer in the Canadian Medical Association.

W. Earl Pollett, by his lifetime contribution to patient care and organized medicine, is deserving to be made a Senior Member of The Canadian Medical Association and will be a welcome addition to the list of distinguished members who have received this honour.

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NOVA SCOTIA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION

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