THE NOVA SCOTIA MEDICAL BULLETIN

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CONTENTS

Co-ordinating Editor – Dr. David A. E. Shephard

Welcome to C.M.A., Halifax 1971

R. O. Jones, M.D., C.M.

Halifax, N.S.

PAST PRESIDENT (1965-66), CMA

It is a great pleasure to welcome the members of the Canadian Medical Association and their ladies to Halifax once again. Despite all you have heard of heavy water and Clairtone, we have not completely collapsed. We hope you will all see enough of our new buildings – Dalhousie for example, when you attend the Annual Meeting, or Scotia Square, or the industrial developments at Port Hawkesbury, or the Izaak Walton Killam Children's Hospital – to confirm this. We hope still more that you will see enough of our province, our seaside cottages twenty minutes from the office, the beauty of our rugged coastline and of our fields and orchards, to get some appreciation of why so many people stay here. Especially we hope you see enough of our people, even our politicians, to find out how friendly and helpful and idealistic they are, qualities that make it exceedingly satisfying to practice medicine among them.

Despite these raptures, one thing used to be missing. Even in my professional lifetime one missed the stimulation and friendship of colleagues from other parts of Canada. air travel has changed all that. Now one frequently sees more of one's Toronto or Ottawa friends than of those in Nova Scotia. We are the better for such contacts. We hope you are too. Insularity has broken down: so much so that most Nova Scotians in 1971 will venture to Toronto without sewing their purses in their underwear.

A big feature in this change of attitude has been the Canadian Medical Association. This voluntary Association of colleagues from all across the country, formed primarily to raise the level of patient care in Canada – as it has done very successfully – and to provide a mutual sharing of professional knowledge and a mutual pooling of brains to work on solutions for the many problems of health care in this country, has also provided a meeting place which has led to firm and affectionate friendships within the Canadian profession. Only someone who has had the opportunity of travelling across Canada and meeting doctors from every province can really appreciate the reality and the warmth of these feelings.

We, in Nova Scotia, feel and have felt a deep and personal investment in the Canadian Medical Association. One of the founding divisions, we gave the Canadian Medical Association its first President, Sir Charles Tupper, and indeed the only President who has ever been elected for three consecutive terms. When Sir Charles finally had to say he could not go on, another Nova Scotian succeeded him, Dr. D. M. Parker. Perhaps our experience of having the oldest provincial Medical Society (1854), closely followed by Prince Edward Island (1855), provided men who could bring the necessary experience to the struggling young CMA in 1867. Be that as it may, Nova Scotia names have continued to be prominent in CMA rosters: a prominence out of all proportion to our population and only matched by the equal prominence of Nova Scotia names in other lists of distinguished Canadians – college presidents, to name but one.

Despite these leadershop talents, things did not always go well in the Canadian Medical Association. Indeed, prior to the 1921 annual meeting, things were so bad that the dissolution of the Society was expected. The meeting that year was in Halifax too, under the Presidency of Dr. Murdoch Chisholm. Rather than disband, the meeting accepted a new constitution, floated a bond issue among the members to take care of debts and to employ a full-time Secretary (Dr. T. C. Routley) – truly a momentous meeting for the Association.

And now we are to have another momentous meeting – the first to have a member of the Newfoundland Division as the President of the Canadian Medical Association. We in Nova Scotia congratulate Dr. Roberts and the Newfoundland Division. We welcome the opportunity to collaborate with our Newfoundland colleagues, mindful of the terrific support the Newfoundland Division gave us in 1965. We have every confidence in the success of your meeting and in the success of the coming year. There is precedent to go by. I chose my words carefully when I said that Dr. Roberts was the first member of the Newfoundland Division to hold the Presidency: he is *not* the first *Newfoundlander* by any means to have this distinguished office. Two spring readily to mind. The first, Sir Thomas Roddick, was born in Harbour Grace. He came to Truro at an early age where he received his basic education and then went on to McGill, eventually to become the President of the Canadian Medical Association and the first person outside the British Isles to be the President of the British Medical Association on the occasion of their meeting in Montreal in 1897. Perhaps he is best known to Canadian doctors because despite great opposition, he was responsible for the formation of the General Medical Council of Canada. He also had a distinguished career as a surgeon and teacher at McGill. The second, our respected contemporary, Dr. Norman Gosse, was born in Spaniard's Bay, Newfoundland, educated there, took his medical education at Dalhousie. He had an equally distinguished career in surgery and teaching at Dalhousie and has been extremely active in all things making for better patient care and the good of medicine in Canada. He was a great President of the Canadian Medical Association, perhaps the most efficient Chairman of Council (a post he held for seven years) of modern times – a striking examples of the Nova Scotia-Newfoundland combination.

So again we welcome all our visitors – and hope you gain knowledge and also have fun. If we natives can help you in any way to achieve these goals, you have only to ask. Please do. □

Our Cover: "Toilers of the Sea" by W. R. MacAskill, F.P.S.A. Pictures of Ships and the Sea.

Courtesy of MacAskill Pictures Ltd., Halifax Shopping Centre and Scotia Mall, Scotia Square, Halifax, Nova Scotia.

Fee for Service

D. L. Kippen, M.D.,
Winnipeg, Man.
PRESIDENT, CMA, 1970-71

The provincial Medicare programs have agreed to make payments to medical practitioners on a "fee for service" basis, in keeping with the traditional private practice of medicine in Canada. Without exception, within a year or so of being in operation, these programs are concerned with rapidly increasing costs and are looking for a method to control this trend. On examination of the payments to physicians there is evident maldistribution to certain segments of the profession and particular concern regarding income which appear to be excessive. Critics of the fee-for-service system suggest that other methods such as capitation or salary arrangement may be the only practical system to provide fair payments to doctors for their services under Medicare. In my opinion, there are important immediate and longterm advantages in maintaining the fee-for-service system provided it can meet certain objectives.

Traditionally, the fee charged for a medical service was an individual decision by the doctor; it varied according to his professional status, the complexity of the service, and the financial circumstances of his patients, resulting in a range of fees for the same type of service. With the advent of third party paying agencies the need for published fee schedules increased, and soon payments by these agencies were based on the fee schedules. Currently, benefits or payments by the Medicare plans are a percentage of each provincial fee schedule.

Most doctors now receive their total remuneration from the government plan and the possibility of a range of fees for a similar service is virtually eliminated and we are operating on the basis of *an average fee for an average service.* This has provided a higher income to those doctors whose type of practice results in a high volume of services and a preponderance of procedural items. Although this maldistribution may be a valid criticism of the present schedules, it does not negate the value of the fee for service system.

To begin with, the original decision to retain the fee-for-service system in the plans was the obvious desire for a smooth transition from a private to a public program, and this has been accomplished in 8 of the 10 Canadian provinces. It also provided the obvious incentive for doctors to work longer hours, a very important factor when medical services are in short supply. Less obvious but equally important, it provided a measurement of the total medical and individual doctor's work load, useful statistical information for future planning of medical services.

The main advantage to the profession of a fee-for-service system is that it permits the doctor an important element of independence. Considering what is practical he is able to determine his own work habits, the type and location of his practice, and the facilities and services which he will provide for his patients. In this *milieu* of private practice the patient has maximal freedom in choosing his doctor or in changing doctors from time to time where this is either desirable or feasible.

It seems obvious that we must analyze the effect of fee schedules on doctors' incomes and the problems of maldistribution including both the large and small incomes generated by current patterns of practice. The top incomes are already a public issue in certain parts of Canada but before considering them excessive one must look at the quantity and the quality of the work being done. It may be that the work load is excessive rather than the income. In any case, following such studies maldistribution can be corrected by appropriate adjustments to a few high frequency items and important ground rules in our current schedules. Although some provincial divisions are better equipped than others to determine the necessary adjustments, once determined *we are all slow in implementing them.* It requires a cooperative spirit between all the different sections of the profession, some may even have to accept a reduced fee in order to achieve equity. However, when such a decision has been reached by our peers, we must support them in carrying out these decisions however unpopular some of their recommendations may be.

It appears that we have reached a point, even at this early stage in the development of Medicare programs, when to raise the income of the lower segments of the profession will require some reduction to the top earners. This by no means suggests that all doctors should receive the same income, nor do we disagree with the concept that within any one group or specialty there should be a considerable range of incomes.

However, it is apparent that there should be reasonable relativity so far as median incomes between different groups, be they specialists or generalists, and that the very high earners and low earners should be analyzed with respect to a satisfactory explanation of their particular situation.

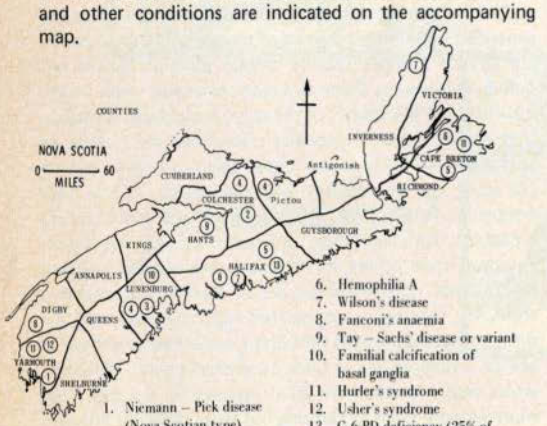
However distasteful it may be to members of the profession to relate fee schedules to medical incomes, the time has come when we must accept this as a reality. The eventual alternatives might be even less acceptable to us and eventually not in the best interest of a first-class Medicare system. □

Nova Scotia and Population Genetics*

J. Philip Welch, M.D., Ph.D.,†

Halifax, N.S.

Population genetics is the study of genetic features and attributes of large groups. Here, in the Atlantic provinces, we are particularly concerned with the genetic features of small inbred groups and with certain other large kindreds, not necessarily inbred, who are more readily available for study than is often the case in North America. This is, of course, attributable to the relatively static nature of the Maritimes population. In Nova Scotia, for example, a large kindred is known in which the gene for Huntington's chorea (the well-known degenerative nervous disorder of adulthood) is segregating, and another in which the gene for Wilson's disease is common. Another large kindred carry the X-linked gene for nephrogenic diabetes insipidus. These and other conditions are indicated on the accompanying map.



1. Niemann – Pick disease (Nova Scotian type)
2. Nephrogenic diabetes insipidus
3. Fabry's disease
4. Huntington's chorea
5. Duchenne muscular dystrophy
6. Hemophilia A
7. Wilson's disease
8. Fanconi's anaemia
9. Tay – Sachs' disease or variant
10. Familial calcification of basal ganglia
11. Hurler's syndrome
12. Usher's syndrome
13. G-6-PD deficiency (25% of male Negroes in Halifax, with lower frequencies in other area of the Province)

The map indicates the approximate geographic location of some (non-chromosmal) disorders in Nova Scotia. Only those occurrences involving two or more cases are included. Collated by E. J. Winsor from material available to the Atlantic Research Centre for Mental Retardation. The list is incomplete and the author would welcome reports of additional cases.

The sceptic may retort that this is fancy knowledge, of possible interest to the medical academic: but what earthly good is it? Part of the answer to this criticism lies in the responsibility which we bear collectively, as physicians, for the treatment and prevention of disease and disability. That is, if we accept the premise that this collective responsibility extends further than simply sitting behind a consulting-room desk and waiting for disease and disability to come a-knocking.

Genetic disease could often be prevented by intelligent, informed counselling; and, in some other cases, early treatment would ameliorate the disability to some extent. Both of these desirable objectives are most easily achieved when the presence of the disease in the kindred is known to a concerned and informed practitioner who has responsibility for the care of the individuals involved. The successful management is clearly dependent on knowledge of the condition under consideration (accuracy of diagnosis is crucial here) and the physician's awareness of individuals in the kindred and the risks pertaining thereto. At present, knowledge of this kind can come only from the extensive investigation of such kindreds on a research basis.

There is another salient advantage to the study of disease in large kindreds. Many such groups are studied on account of the relatively frequent occurrence within them of an otherwise rare condition; thus the investigator accumulates a number of examples of the rare condition under study in relatively "pure culture" and substantially free of errors due to incorrect diagnosis, such as might be expected to occur in any given series of cases culled from the medical literature. In this way the investigator has the opportunity to accumulate data on a large number of individuals with the studied disorder. This is frequently a most useful tool in the delineation of the condition and in the discovery of genetic heterogeneity.

A study, currently in progress in one area of Nova Scotia, illustrates this. In 1958 it was noted by some U.S. investigators, that among some children with Niemann-Pick disease were four whose condition seemed different from the "classical" disease: in all four their ancestry was traced to the same area of Nova Scotia.[1] Occasional similar cases have been reported since. Over the past two years an extensive investigation of the population group involved has uncovered some 12 examples with similar history and findings to the cases described in 1958, thus firmly documenting the existence of a distinct genetic variant of this disease.

The study of large inbred groups, for whatever reason, also commonly throws up examples of previously unrecognized recessively inherited genetic disorders. This is not attributable to any kind of "genetic deterioration", but occurs simply because inbreeding increases the chances of individuals becoming homozygous at any given locus, thereby increasing the probability that a recessive trait in the deme‡ may become manifest.

Doubtless some will question the value of these investigations, and for others the fact that the results add to man's knowledge of his own genetic background constitute insufficient justification. It is pertinent, therefore, to consider the practical application of this information.

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‡Deme: A consanguinial kin group, or local endogamous community.

First, the careful delineation of single genetic conditions assists in diagnosis; a point which may be important, for example, in distinguishing classical phenylketonuria from the relatively innocuous hyperphenylalaninaemia. Second, documentation of a "new" recessively inherited disorder allows the informed physician, when consulted by the family who have produced the child suffering from the disorder in question, to make useful prognostications regarding the risk of having a second affected child.

These are some of the practical applications of population genetics. While there is a considerable gap between the practical and the academic, some would still argue that their separation is neither practicable nor desirable. One of the most important academic aspects of this subject is the elucidation of genetic characteristics of different populations; although primarily of academic interest, it is an area considered by some to be the most important for present and future studies.

Many polymorphisms exist in man, of which those now known are probably but a small proportion. New biochemical and serological techniques continue to uncover diversities, but the mechanisms maintaining this genetic variation are poorly understood. The genetic study of isolated, relatively primitive populations may give us some insight into our own genetic history and some clue regarding the factors at work in changing or maintaining the pattern.

In a very few instances, the classic example being HbS, the association of a particular environment with a certain genotype has served to indicate the mechanism maintaining the genetic diversity. Knowledge of the genetic constitution of different populations has enabled us to trace, in some degree, population migration. For instance, by this technique we can estimate the amount of racial admixture of white and black populations currently seen in the American Negro. A further example is provided by the clines mapped out for the frequency of blood groups in the Old World. These are believed to be the tracks of previous population migrations: truly footprints in the sands of time.

In Nova Scotia, investigations of the frequency of the gene for glucose-6-phosphate dehydrogenase deficiency has disclosed the presence in some groups of a far higher frequency of this gene than would have been expected.[2] Although the significance of this is not yet clear, the practical medical significance of the finding that over 25% of Negro males in the Halifax area are G6PD-deficient cannot be overlooked.

The potential of the Atlantic provinces for this kind of research has been neglected for too long by those of us who, since we are engaged in population genetics in the area in question, should be most actively concerned. The intrinsic interest of some of our populations is highlighted by the fact that their potential has been recognized and exploited by investigators from university centres further afield. Certainly, the most important consideration is that the work should be competently carried out by appropriate investigators; nonetheless, we have a responsibility to the local population to carry out these studies, since the practical consequences are most pertinent to those same populations.

The modern trend is for population barriers to break down as mobility increases. With the passage of time, it becomes increasingly difficult to obtain information on the genetic constitution of semi-isolated population groups. Time is running out. □

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Ages 31-40	42.00	38.50	35.00	31.50	28.00	24.50	21.00	17.50	14.00	10.50	7.00	3.50
Ages 41-50	70.00	64.17	58.33	52.50	46.67	40.83	35.00	29.17	23.33	17.50	11.67	5.83
Ages 51-55	124.00	113.67	103.33	93.00	82.67	72.33	62.00	51.67	41.33	31.00	20.67	10.33
Ages 56-60	188.00	172.33	156.67	141.00	125.33	109.67	94.00	78.33	62.67	47.00	31.33	15.67

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Day Month Year

Prov. *Country*

4. (a) Residence ..... *No. Street* *Town or City* *Prov.*
(b) Previous residence within two years .....

5. Do you intend to reside or travel in another country?
Where? .....
When? ..... How long? .....

6. Have you flown, except as a passenger on scheduled airlines? .....
In what capacity? .....
When? ..... Date of last flight? .....

7. Do you intend to fly, except as a passenger on scheduled airlines? .....
In what capacity? .....
Details .....

8. Have you ever been refused insurance or offered insurance with any extra premium, rating or lien? ..... When? .....
By whom? ..... Reason? .....

9. *(a) State total amount of insurance in force on your life .....
*(b) Additional Amount of Accidental Death Benefit now carried .....
*(c) Additional amount of Family Security, Term Riders, etc., now carried .....
*If none, state "none"

10. (a) Your height and weight in ordinary clothing ..... ft. ..... ins. ..... lbs.
(b) Any recent change? ..... loss ..... lbs. or ..... gain ..... lbs.
(c) Reason .....

11. Have there been any deaths from heart or artery disease in your family? .....
(Show ages at death and cause) .....

12. (a) Have you ever used alcoholic beverages to excess or intoxication? .....
(b) Have you ever been treated for abnormal use of alcohol or drugs? .....

13. Are you now in good health and free from all symptoms of illness and disease? .....

14. (a) Name of your Medical Advisor? .....
(b) Address .....
(c) Date last consulted? .....
(d) Reason? .....
(e) Result? .....

15. List the illnesses and operations which you have experienced, giving particulars, dates and names of physicians consulted. (Minor illnesses such as common cold followed by prompt recovery need not be listed.) If none, state "none".

Illness or Operation	Date and Duration	Physician, Hospital, etc. (if any)	Result

16. Have you had, or have you been informed that you have ever had any abnormal condition not mentioned above? .....
If so, please give details and dates .....

17. Number of units of insurance now being applied for: Have you previously been insured under this plan? Yes ☐ No ☐

18. Beneficiary in event of death—
Name (full given names) ..... Relationship .....

The statements contained herein are true and complete and form the basis of any certificate issued hereunder. I agree that any material misrepresentation shall render the insurance voidable at the instance of the insurer. I authorize any physician or other person to disclose to the Company at any time or times hereafter all information in their possession as to my health and medical history upon the production of this application or a photo copy of this application to such physician or person. Suicide within two years of the date of the certificate is a risk not covered.

Dated at ..... this ..... day of ....., 19.....

.....
(Witness)

.....
(Signature of life to be insured)

.....
(Address)

A View from the Ramparts

Harold L. Scammell, M.D., C.M.,

Halifax, N.S.

Every visitor to Halifax should see the Citadel. It is one of the great historic sites of Canada. Within its viewing range Nova Scotian and Canadian history has been in the making for over 220 years. Inside the fortress there is much to be seen; the museums can occupy an afternoon in themselves, but every member of the Canadian Medical Association owes himself a visit to the ramparts. Let him ascend the steps up the granite wall and look to the entrance of Halifax Harbour.

To the left of the entrance is a large island, McNab's Island, and there, a half-century ago, the Canadian Medical Association was revived and revitalized. World War I was over and Canadian medicine had started to adjust itself to a new era. The old way of life had vanished, perhaps forever, and suddenly the doctor found that his old fortress of rugged individualism was being breached on every side. At the annual meeting it was the inspiration of genius that made the featured entertainment a picnic on McNab's Island. There, far from the meeting halls and the clinics, "far from the maddening crowd", the members were able to toss cares aside. Men from the West met men from the East and decided they had much in common. Former comrades-in-arms met again and recalled the days when they had worked together in a common cause. Again they relived the words of the great hymn, "We are not divided, all one body we". The spirit gained strength and permeated the rest of the meeting. The Canadian Medical Association dug in its toes, went ahead, and never looked back from that day.

Speaking of spirit, perhaps that of Dr. Charles Tupper was around that day. In 1866 he was Medical Officer for the City of Halifax and Dr. W. D. Slayter was Medical Health Officer. The ship "England" arrived off McNab's, flying the dreaded signal of Asiatic cholera aboard. It was not the first time this had happened, and it reduced the inhabitants to a state bordering on panic. In his line of duty Dr. Slayter went out to the "England", now in quarantine, remained to treat the victims, contracted the disease and died there. He with the rest of the dead were buried on that beach you can see extending from the Island.

Meanwhile Dr. Tupper was attending to his duties in the city. The terror of the people had to be brought under control, any cases reported and treated as early as possible, and facilities for treatment in isolation provided. Look closer to the city and you will see the grain elevators. Near the shore in that spot was a modest dwelling occupied by a family. The mother saw some clothing lying on the beach, and without knowing that it had been cast overboard from the cholera-infected ship, she brought it in, dried and used it. Soon there was cholera in the house. Dr. Tupper went into action at once with facilities already provided, and the next day returned, set fire to the house and burned it down. It was an example of his forthright action; nobody raised even a murmur of protest.

Dr. Tupper, later Sir Charles Tupper, a Father of Confederation, a Prime Minister of Canada, and the first President of the Canadian Medical Association, was a man of foresight, a man of action, and a man whose memory today is perpetuated in the Sir Charles Tupper Building, nucleus of Dalhousie's School of Medicine, which you can also see from where you stand.

Nearer, but in line with your gaze towards McNab's you will see the steeples of two churches. The one to the left is that of St. Matthew's, to the right is St. Mary's. Just beyond the former is Government House, residence of the Lieutenant Governor of Nova Scotia. In this area the first hospital in Halifax was built of logs, "a musket shot beyond the South Gate". Its staff and equipment came in the Cornwallis Expedition for the founding of Halifax in 1749.

A few years later as the forest was cleared to the south, a number of small houses might be seen. These sheltered those who chose innoculation against smallpox. The subject was directly innoculated from a person with a mild case of the disease in the hope, not always realized, that a mild case would also result in the subject as well. The small houses had accommodation for two persons only, and they remained in isolation until the disease was over. The attendant of course was one who had acquired immunity from an attack.

Just to the right of the steeple of St. Mary's Basilica, on Doyle Street, was the second hospital in Halifax. It began as a "poors' asylum", a shelter for indigents. It was soon opened to petty offenders and to the indigents who were ill. It was known as The Bridewell. Those who died there were buried in "The Pauper's Burying Ground" now occupied in part by the Halifax Memorial Library. When epidemics happened, the deceased were buried in long pits; a story is told of a man so interred at night whose grave was not filled in, being found sitting on the edge of it in the morning. The Bridewell in time became a haven of distress and misery, and for the elderly and homeless a last haven. At this hospital also, the first surgical operation on a patient anaesthetized by chloroform was performed by the Halifax Medical Officer, only a few weeks after Simpson published his paper on chloroform and its use in Edinburgh. The operation was the amputation of a thumb; it was done with the patient sitting up in a chair! It is recorded that she felt no pain whatever.

From your point of vantage it is easy to see the Victoria General Hospital. Behind the massive structure and almost overwhelmed by it is the original City Hospital, built in 1858 through the urgings of Dr. Tupper who condemned the old Bridewell in forthright terms.

Across the Harbour, you can see the Nova Scotia Hospital, an institution built through the urgings of Dorothea Dix, the great American reformer in the humane care of the mentally ill.

By this time you may feel that you have had enough of the view, but before you go I would ask you to come for just a moment to St. Paul's Cemetery, across Spring Garden Road from St. Mary's Basilica. It is over a century since there was a burial there. On a very modest headstone slowly sinking below the turf is the record of the burial of two children who died of what would be called diphtheria today. After the record comes the comment: "Consider stranger whether disease or medical ignorance hath clad most in their last claith." This is the voice of sorrow and of anger. Was it justified? We do not know. But none of us can read this and take it lightly. If our profession means anything to us these words surely enjoin us to remain students always, to try our best to keep up with progress, to be aware of our personal limitations, and to gain the help when needed from those who know more than we do.

Now we hope that you have enjoyed this view from the ramparts of the ancient Halifax fortress that helped it to be "the Warden of the Honour of the North", as Kipling put it. We hope it will help you carry away memories that will help you in the days and years that lie ahead. □

Nova Scotia: A love story

Arthur L. Murphy, M.D., F.A.C.S.,
Halifax, N.S.

Once upon a time, before video cassettes, and before television by cable or ether, and before the talking picture, and almost before radio, when the movies flickered and all real theatre was live, my father stepped off a trolley car at the corner of Spring Garden Road and Barrington Street in Halifax, in front of the Academy of Music. He was on his way to his daily rounds at the Halifax Infirmary, one short block from the corner. The day was a March day, raw. A blustery, March rain beat him with pellets as it had his Ford coupe. The Ford has said, "No", but he was the stronger, hence his passage by public transit.

The Academy of Music, a fine theatre of the old tradition, progenitor of today's Neptune Theatre of which Nova Scotians are proud, that got its name in an earlier era, served a resident stock company from autumn till spring, and visiting musicals throughout the summer. As motion pictures grew, and, beyond the great centres, pushed live stage back, it changed its name to the Majestic which somehow seemed more fitting for a theatre which put a big screen beneath its proscenium and showed films when live, better drama was not available. Years later, it succumbed completely and was torn down to make way for the Famous Players Capitol Theatre. But on this morning its facade was garish with posters of the current production by the J. J. Carroll Players, an American company. And under the marquee, coat collar turned up against the rain, hands stuffed deep in his pockets, was J. J. Carroll himself.

My father smiled. He said, "Good morning, Mr. Carroll! A beautiful morning!" He walked on.

"Yes, isn't it?" said J. J. Carroll, enthusiastically.

My father stopped. He turned back. He said, "You sound as if you really meant that."

"Oh, I do. I do!" said J. J. Carroll. "The variety of your climate is magnificent."

Recently, as chairman of the University Grants Committee for Nova Scotia, I met with representatives of a provincial university faculty who complained that their salaries were below Canadian averages. While in sympathy with their plight, I did point out that they had a problem in common with most other Nova Scotians. After our meeting a younger member of the faculty, of great ability and a national reputation, whom I knew had turned down an offer from a central Canadian university of almost twice his current salary, said to me, "What some of them don't make allowance for is the land – the valleys, woods, streams, lakes – the sea and the feel of Nova Scotia."

In Ottawa's statistical records you may learn that Nova Scotia is a depressed area. These records have been inscribed by skilled businessmen who record the value of land by what it produces, the value of timber at its current market price, the value of streams by their hydroelectric potential, and the value of the ocean by its population in fish.

Writing in dollars, they are correct. Dollar-wise, Nova Scotia is poor (although she can, on Wall Street, negotiate loans at better rates than seven of our ten provinces). But dollar men, properly for them, have not weighed in their balances the magnificent varieties of J. J. Carroll or my professorial friend.

Turn from the dollar men, ask a sailor under canvas (or dacron), who has beaten up Nova Scotia's granite-clad coast, who has sailed the Bras d'Or Lakes, which Gilbert Grosvenor, longtime editor of the National Geographic magazine, called the most beautiful salt waterway in the world; ask the salmon and trout fishermen who toss their flies on the Margaree river or the Liscombe, ask a deep sea fisherman, battling for hours against a tuna off Wedgeport; ask the artists who come to paint in the fishing villages, in the orchards of the Annapolis Valley, and in Halifax, seeking out the quaint, old buildings preserved in the midst of the new, upreaching city; ask *them* if Nova Scotia is depressed.

In my medical school days, as a summer-time cub reporter for the Halifax Herald, I was sometimes privileged to share a beat with the Morning Chronicle's Horatio Crowell. He wrote about Nova Scotia, "Did it ever occur to you that the Creator may have left this little sea-girt peninsula until the last? That he may have reserved for it many of the treasures of his workshop? That after he finished his great masterpiece he may have spent aeons in molding those features of this province which possess such delicacy of beauty, such subtlety of charm, that, travelled the world over, we may find them unexcelled and without peer?

"Did you ever think that when this world was coming out of chaos, the Creator might have set aside ever so little of the congealing mass upon which to imprint his own special design? Have you not thought of the divine hand pressing a finger upon the soft clay and behold a valley here, another there? Have you not seen in the wonderful contour of hills and mountains of this land the divine imagery of what hills and mountains should be? Have you never yet heard through the forest, through the orchards, over fields and meadows, the breath that gave it life? Did it never seem strange to you that this is a land without tempest, or flood, or drought, or gale, or pestilence, or if you did, did you ever think that the reason may be, because it is God's land?"

Depressed area?

Halifax is developing a container port which it is said may rival New York a few years hence. Hawkesbury, on the Strait of Canso, boom town of the eastern Atlantic seaboard with its calm, deep waters, its oil refinery, pulp mills, heavy water plant, is to grow to one of the world's great ports. There are secrets, half kept, of oil wells already tapped and capped off Nova Scotia's coast. After years of study practical means have at last been developed of harnessing tidal power. The Bay of Fundy, on Nova Scotia's north shore, with its 30 foot rise and fall, has the greatest tidal bore and possibly the greatest hydro-electric potential on earth.

What of the future?

At night with my prayers I often toss in a selfish quickie, "Thou knowest, Oh Lord, that the ultimate depressed area is Hell. From Hell protect us, dear Lord, but please do not destroy our beloved Nova Scotia with too great a prosperity." □

"To study medicine without books is to sail an uncharted sea, whilst to study medicine only from books is not to go to sea at all.'

Sir William Osler

Between the Wilderness and the Sea

James C. Vibert, M.D., F.R.C.S.(C),
Truro, N.S.

In Nova Scotia we still live between the wilderness and the sea. It is a land that is relatively unpolluted and underpopulated. It is not intensively cultivated nor highly industrialized so that making a living here has never been easy for most people. However it is a good place to practise medicine. The hardy, independent people usually accept serious illness and death with great fortitude and without recrimination.

The wilderness does not extend for vast distances. It has been penetrated for many years by lumbermen and miners, hunters and trappers. Now it is being changed more rapidly by the pulp companies with power tools and tree harvesters. It is being crisscrossed with new and better roads. Still much of the wilderness remains. The boglands and forests hold rainfall and the lakes and rivers run high. There are places where the only night sounds are those of the loon and barred owl. Blueberries, blackberries, strawberries, raspberries, elderberries, wild apples and crab apples grow without cultivation. Water lilies and asters, goldenrod and dandelions, mayflowers and violets, wild roses and wild plums, buttercups and daisies and myriads of others spring up and fade each summer. I know a single river system that yields each year catches of shad and striped bass, smelt and gaspereaux, trout and salmon. Spruce and maple spring up in woods and pastures without being planted. The salt marshes of Northumberland Strait and the Bay of Fundy are still partly unspoiled. The rocky lakes of the south shore are not greatly changed since the Laurentide Glacier receded.

The sea is all around us. It modifies our climate. Its summer fog often hides the sun but it waters the vegetation and cools the nights. It is a never-ending source of enjoyment: fishing, boating, swimming, sailing. If we contemplate it at all it teaches us patience and humility. Its food supply still seems inexhaustible: not only cod, pollock, tuna, herring, mackerel, haddock, swordfish and lobster but also clams, oysters, quahogs, scallops, crabs and periwinkles. And although in Nova Scotia we have only a few thousand square miles of land we have thousands of miles of sea coast. Surely there will always be parts of it where we can see only natural beauty and hear only surf and sea birds.

Change comes more slowly in Nova Scotia. The people resist it, finally accept it reluctantly. The isolation of the backwoods farm and the tiny fishing hamlet, the loneliness of the wilderness and the sea is not readily unseated. To the Nova Scotian with "so brave and simple a heritage, with pithy intelligence and no end of native resource no tool is strange, no branch of do-it-yourself discipline outside his ken".[1]

> "These were men of pith and thew
> Whom the city never called
> Scarce could read or hold the quill
> Built the barn, the forge, the mill."[2]

At last there are signs that man is learning to cherish the wilderness. If so, may there always be a place in Nova Scotia for these people. □

[1] Howard T. Walden, II, *Anchorage Northeast.*
[2] Thomas Mulden.

ADVERTISERS' INDEX

Welcome, Federation of Medical Women of Canada

In these days of divisive distaff dialectics, it is refreshing to recognize equality where this is due. The position of women in medicine is a case in point. Prejudice and antagonism towards women who join the medical profession is singularly lacking; indeed their special talent for the practice of medicine are recognized and appreciated. It is therefore a pleasure to welcome the Federation of Medical Women of Canada (FMWC), especially as the Federation will be hosting the welcoming reception for delegates and guests to the CMA Annual Meeting in Halifax, during the evening of Sunday, June 6, 1971.

The FMWC was founded in 1924, with the broad objective of promoting the interests of medical women in Canada. The Federation soon became an affiliate of the Medical Women's Internation Association, and in 1964, it became affiliated to the CMA. As such, the Federation has a seat on the Council of the CMA, so that medical women as a group, as distinct from women as individual doctors, are represented in the CMA.

Each area of Canada is represented in the Federation; at present, however, the Atlantic Provinces have only one branch, in Nova Scotia. Like its sister branches, it is chiefly concerned with the administration of funds directed to the financial support of women medical students, and with encouraging women to enter medicine. Two funds are of interest. The first is the Maude Abbott Scholarship Loan Fund, a national project, which was established in 1939 in memory of one of Canada's greatest medical women; loans and academic awards are financed. The second, of local interest, is the Roberta Bond Nichols Memorial Fund, which is used to provide a Book Voucher for the woman medical student having the best academic performance in Anatomy each year. Roberta Bond Nichols is well remembered in Halifax, where she devoted her medical time to the practice of anaesthesia at the old Children's Hospital, and to teaching anatomy in Dalhousie's medical school, as well as writing the Personal Interest Notes Column of this Bulletin.

Apart from the management of financial aid, the Federation encourages women to enter medicine, and to become more active within the medical profession. It may be that this is an area with which the FMWC will become more concerned, as the responsibility of the medical profession to society grows. An indication of this is the Federation's interest in Family Planning, a committee report on which is presently being prepared. However, it is not always easy for busy women doctors who are directly involved in active clinical practice, who are therefore particularly concerned about socio-medical problems, to take part in the Federation's activities. The present membership of the local branch of the FMWC is small, and one objective of the local group is to encourage growth in membership, especially among the younger women doctors. Enquiries are welcome: Dr. Enid Macleod, Department of Physiology, Dalhousie University, and Dr. Anne Hammerling of Halifax, who will be the 1971-72 President of FMWC, would answer these.

The Medical Society of Nova Scotia greets the FMWC on its visit to Halifax for the CMA Annual Meeting. The Society supports its aims, which are symolized by the emblem of the Federation (the staff and snake of Aesculapius with the addition of a single wing): the spread of peace through the alleviation of disease and ignorence. Medical women are in a special position to exert their influence in society: the work of FMWC deserves our support. □

D.A.E.S.

Commentary

Health Care of Youth: A Bits-and-Pieces Affair

L. E. Ranta, M.D.*

Vancouver, B.C.

Last summer, more than 100,000 girls and boys from mid-teens to mid-twenties roamed from city to city across Canada. Many were penniless and alienated from society. Their way of life created a health problem: boredom, malnutrition, the abuse of drugs and the prevalence of infection being the chief causes.

The disorders affecting these young people ranged over all youthful human ills, but "misuse" diseases were prevalent as well. Intestinal and respiratory diseases, unwanted pregnancies, "freak outs" and mental disorders were frequent, while outbursts of gonorrhea and syphilis increasingly flagged maps across the country. Hepatitis was a problem too: today, some of those who contracted the disease from dirty needles are still in hospital.

This new health problem was bad enough last summer. Conditions threaten to be worse this year. How should we meet this problem?

Let us first consider what we did last year. Hospitals functioned, as hospitals do, giving emergency and out-patient services to those who managed to seek them out; but dedicated, by tradition, to the orthodox pursuit of health, many hospital workers showed scant sympathy for the "street" people. Hospitals hung back for another reason: they wished to avoid sinking deeper into debt incurred by expenditures in unexpected directions. Few doctors working in private offices moved into the street scene. Whatever the reasons, often understandable, one consequence was that social centres set up by youth for youth were impelled by necessity into providing backstreet medicine, and there was little interaction between "straight" resources and "street" improvisation. The cry for help was made only when serious illness or panic overcame the rejection of "straight" services by the less orthodox persons in our society.

The response to this problem was a bits-and-pieces affair. A few dollars were hard won from a few voluntary and official services, and some 40 "street" clinics sprang up in different cities. Not surprisingly, many were operated by novices in the provision of health care and in the ways of meeting social needs, and there were many unhappy experiences.

What is the scene today? At least there is some recognition of the issues, as evidenced by a recent national Symposium on Hospital Responsibility toward Drug Users. A dialogue was established: "short hairs" from hospitals discussed health problems with "long hairs" from street clinics. The scene perhaps is changing; one symposium speaker remarked: "Street clinics are losing ground. The kids want to see a 'real' doctor."

Nevertheless, some decisions reached at the symposium suggest that the recommended treatment is "the mixture as before". Governments plan to spread a little money as widely as possible. Hospitals see themselves as back-up resources. Street agencies assumed the posture of Nouveau-establishment. The impression was that of fragmentation into islands of health care. But should the health needs of dislocated youth be met simply by bits and pieces?

It is already too late to do much for this summer. Yet we must not waste time, and realistic planning must be started at once for next year. Canada's health resources equal the world's best. These resources, the personnel and the facilities, must be channelled at once to meet the needs of transient youth. The medical profession, public health experts, and hospital authorities cannot avoid the responsibility to organize youth services. The bits-and-pieces game has gone on long enough. □

*Medical Director, The Vancouver General Hospital, Vancouver, B.C.

A (Medical) Father's Reflections on Nursery Rhymes

Jack Sprat could eat no fat: he had cholecystitis. Little Jack Horner sat in a corner because of a personality disorder, and today Mary Mary would be referred to the Child Guidance Clinic for being so contrary. The Old Woman who lived in a shoe, and had so many children that she didn't know what to do, should obviously have gone to the Family Planning Association. Little Boy Blue suffered from a right-to-left shunt, and Humpty Dumpty probably had fragilitas ossium. To announce oneself as King of the Castle while others are dirty rascals confirms delusions of grandeur. Simple Simon presents no problems in diagnosis. Tom Tom the piper's son, who stole a pig and away he ran, was a juvenile delinquent; even Old King Cole who was such a merry old soul sounds as though he was too fond of the bottle.

And was the Cow who jumped over the moon the first bovine astronaut blast off by a cat using the fiddle as a launching pad?

J.A.R.T.

* * * * * *

Of Drugs and Paper Rats

The following report* has been received. It concerns some of the lesser known side-effects of the common analgesic, acetylsalicylic acid; because of the importance of the conclusion, it is printed in its unabridged form.

"BIOTRANSFORMATION OF GLUCOSE LABELLED ACETYLSALICYLIC ACID IN RATS.

The Incidence of Unfortunate and Reprehensible[1] Side-effects of common Pharmaceuticals or even some common Food Elements is highly Anxious to Physicians who are the Curators of Mankind. An Experiment which describes a Peculiar Consequence to an Experiment to study the Side-effects of the Universal Analgesic Balm, Acetyl-Salicylic Acid, to which must now be added the Confirmation of Addiction in the Rat species[2], is herein reported. Although this Addiction effectively prevented the Ultimate Completion of the Task in a sufficiently satisfactory Manner to permit us to obtain unbiased Data suitable for critical statistical Analysis,[3] the Experiment is presented because there is a Moral somewhere.

MATERIAL AND METHODS. Common (or garden) Acetyl-Salicylic Acid was prepared from its Iodized[4] salt and was labelled with Tritiated Glucose. We used the Brown Sugar form, having the general formula $(C_6H_{12}O_6)n_4O$, according to the Method of Sweet, Tooth and Pain (1907). The molar extinction coefficient of the product in 0.9N HCl was $\epsilon_{101} = M^{-} cm^{-}$ and its Acetate content was 101.1%.[5] Periodate oxidation was done by the Addition of 5μ moles of Kitchen-type Baking Soda. The Compound was seasoned, according to Taste (1917) and refrigerated.

After a Breath-taking Chase,[6] 77[7] adult male hooded, double-tailed Rats (Ecum Secum strain) were introduced into Plastic House to make them Docile. On the 7th Day of Incarceration, they were divided into two equal *(sic)* Groups of 7 and 70 in Number, and fed with a Diet containing 7.7 mg/kg of the Tasty ASA daily. Water and Rum were provided *ad libitum*. After 7 days, by which Time the Rats had developed a strongly Positive Nausea Reflex, they were Sacrificed in Pairs,[8] and frozen forthwith in cool, cool Liquid Nitrogen (Dunkin and Ice, 1777). Each Rat was weighed, dissected, and Crispy Slices of all Tissues were cut and stored at −77C, pending Analysis.

RESULTS. These were highly remarkable. The Tissues were all Changed in their Nature. The Tissues were Papery, even rustling on Palpation. Chemical Analysis indicated with a High Index of Suspicion that all the Tissues had been Magically transformed into a Chemical Substance having the General Formula of $(C_6H_{10}O_5)n$, its α Form being Predominant. It was Highly Significant that Cellulose Acetate was identified, for this is well-known as a Constituent of Paper.

CONCLUSION AND MORAL. *A Drug is a Substance which, when Administered to a Rat, produces a Paper."* □

D.A.E.S.

*By Prof. X. Pert, Institute of Transmogrification, Nirvana.

1. The author's quaint use of the English language has been preserved, as it appears that this report may become a classic in the pharmacological literature; it is therefore something of a scoop.—ED.
2. However, the well-known "whisker and tail withdrawal effect" has been reported previously in single-tailed rats only. The effect of addiction in double tailed rats has to be seen to be believed.—ED.
3. He means: "We goofed".—ED.
4. Probably a typing error; presumably the author means "Ionized". However, it tastes the same.—ED.
5. This doesn't make sense to me, either.—ED.
6. cf. Tales of A. Farmer's Wife and Three Visually-Disadvantaged Mice.—ED.
7. The recurrence of the number 7 throughout the report is curious. In a telephone communication, the author reported that one of his assistants, now in a hospital for nervous ailments, was obsessed to the point of absurdity with number 7. She even had 7 left toes.—ED.
8. There is a discrepancy here: what happened to the lucky one who was unpaired is not known. The author does not refer to the method of Noah and Ark (777 B.C.), which is a classical reference to the problem of pairing singletons.—ED.
9. $t = 2.21$, $P < 0.005$.

VOL. XIII NO. 2 **Newsletter** APRIL 1971

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Contents

ASSOCIATE EDITOR – Dr. C. A. Boddie BUSINESS MANAGER – Mr. Gerald F. Lynch

WELCOME C.M.A. 1971

H. D. Roberts, M.D.,

St. John's, Nfld.

PRESIDENT-ELECT, CMA, 1970-71

The **Newfoundland Medical Association** is very pleased and honoured to be the Host Division for the Annual Meeting of the **Canadian Medical Association** this year. Newfoundlanders are very proud of the quality of medicine which has been practised in Newfoundland throughout the centuries, dating from the days when the only medical practitioners in the Island were naval surgeons who came out with the Fishing Fleet from England. Thus, from the sixteen-hundreds to the present an interesting and productive record of progress has been the story of medical history in this province. The latest achievement to provide medical services for our Island home is the founding of the Medical School at Memorial University. This is a pioneer development in the new curriculum of medical education.

All Newfoundlanders are very proud of the hospitality they extend to visitors, and the one regret of every member of the N.M.A. is that they have *not* adequate facilities to host the Annual Meeting in the Province. However, we are pleased that the Directorate of C.M.A. is going to meet in St. John's prior to the Annual Meeting in Halifax. In Halifax, with the full co-operation of our sister Societies in the Maritime Provinces, the warmth of true Atlantic hospitality awaits you, and we hope that all who come, will enjoy the visit.

The members of CMA are always welcome in Newfoundland, and we hope that you will, at some time, visit us. The officers of the local Division will be pleased to know of your coming, and they will do everything to make your visit enjoyable. □

W. D. Parsons, M.D.,

St. John's, Nfld.

PRESIDENT, NEWFOUNDLAND MEDICAL ASSOCIATION

Newfoundland, as host province, welcomes you to the 104th CMA Convention. We welcome you in Halifax with the same hospitality that we only wish we could show you in St. John's and Newfoundland.

We have heard of and received the hospitality of the West, the friendliness of Ontario, the "Bienvenue de la belle province" and, as a part of the Atlantic Provinces, have a togetherness with Nova Scotia, Prince Edward Island and New Brunswick. In Newfoundland, where for so long we were isolated by geography, it is only in the last ten to fifteen years that travel by road and air have replaced long boat trips to outlying areas. There are still a few such places but they are becoming fewer and fewer. Many of us have connections with this island for over 300 years, but most of us are removed by less than a generation from the isolation that lets us welcome any visitor to our homes and our hearts.

This was the type of isolation that let us welcome any stranger as a friend. A fact that will be well remembered by so many who visited our island during the war years and especially those who took a wife with them from here.

So it is that the youngest Division of the CMA recognizes the honour of being the host province and having Dr. H. D. Roberts as the next President of the CMA. Dr. Roberts is the first member of the Newfoundland Medical Association to be President of the CMA, though we look back with pride on other Newfoundlanders who have served Canadian medicine in high posts in the CMA: Sir Thomas Roddick, Dr. Norman Gosse and Dr. Tom Quinton.

(cont'd.)

They represent the many other Newfoundlanders who favoured Canada with their presence over the years. I am sure that they, with all of the members of the Newfoundland Medical Association, welcome you to this Convention.

Any of you can pick up tourist folders and various books that will show the beauties of our province. We have tried in the articles in our Newsletter to give you an insight into the background of our history and some of the medical institutions that make Newfoundland so unique. We hope, as you read these articles, you will reflect the part that history has played in molding Newfoundlanders as you know them today.

So come-all-ye and enjoy yourselves. □

The Caplin Scull

The picture appearing on the front cover of the Newfoundland Medical Association Newsletter was taken by a professional photographer, Mr. Ben Hansen. It was taken at Ferryland, a small fishing community located approximately 75 miles from St. John's on the Southern Shore of the Avalon Peninsula.

In Newfoundland folklore, the caplin scull is the local name used to describe the type of weather that usually exists during the time of year when the caplin hit the beaches of Newfoundland. This weather is usually mild, foggy, and drizzly.

The caplin is a small fish, about 5 to 6 inches in length, and they come in and throw themselves on the beaches in millions to spawn and die. For the local people, these prove to be a delicacy for eating. The farmers and fishermen load these aboard their horse and carts and bring them to their fields where they are used as fertilizer. It is quite a sight to see millions and millions of these little fish glistening silver in the water and actually making the water boil and come alive with their activity as they throw themselves upon the beaches. The caplin serve another very useful purpose in that they are the main source of food for the codfish at that time of year; and when they come to the beach, they lure the codfish close to land which helps provide a livelihood for the Newfoundland inshore fishermen. □

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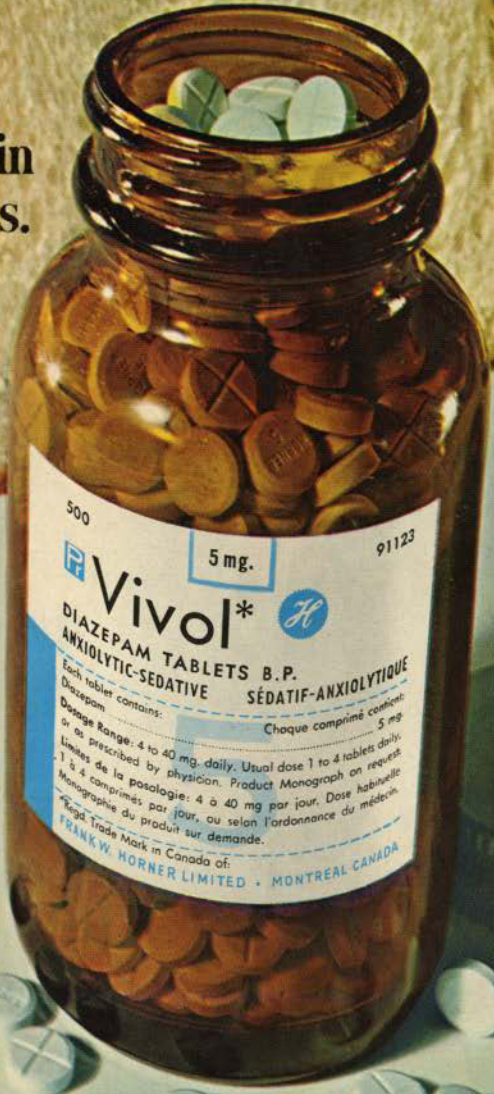

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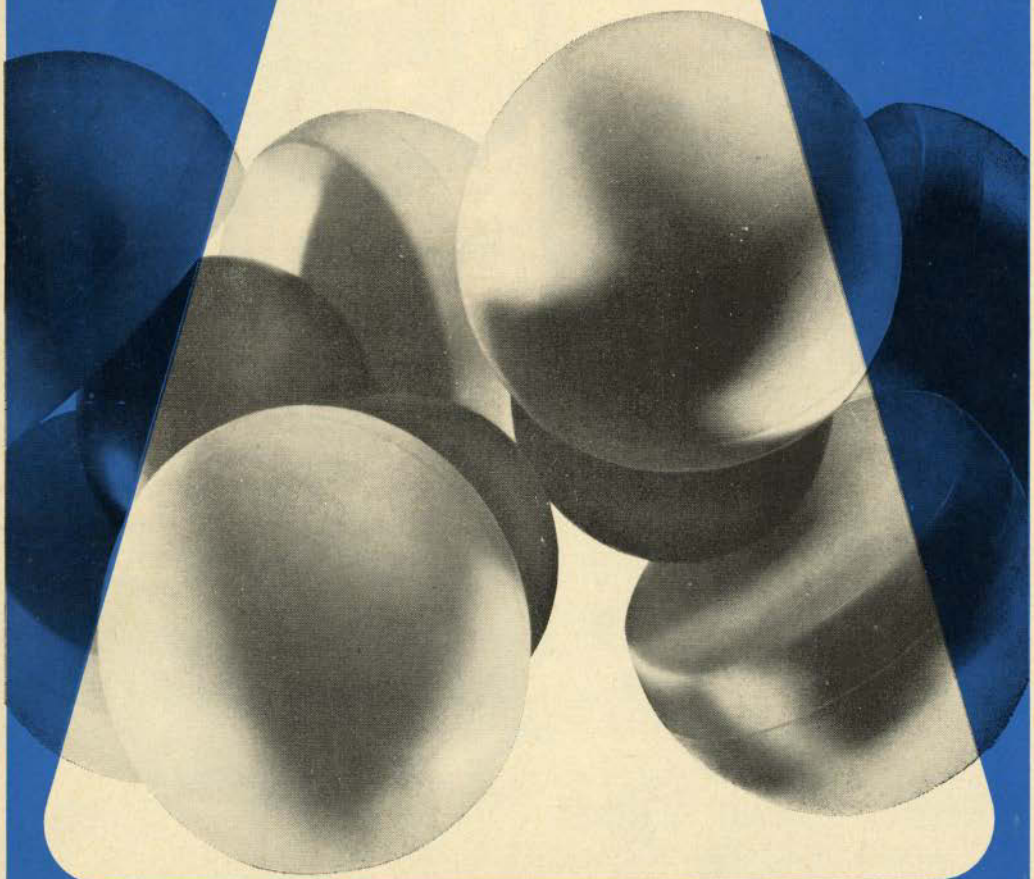

Hoffmann-La Roche Limited, Montreal

A BRIEF HISTORY OF MEDICINE IN NEWFOUNDLAND

W. D. Parsons, M.D.,
St. John's, Nfld.

The early history of Newfoundland is shrouded in the mists of antiquity. The highlights were recorded but little of the day-to-day existence of the inhabitants remains and even less of the medical history. One must remember that medical care of most people in the 16th, 17th, and even 18th century was haphazard, to say the least. A few physicians served the nobility and wealthy. The family doctor of the day was the apothecary who concocted nostrums with many ingredients, most ineffectual. Itinerant barber-surgeons, bone setters, and cutters for the stone did their bit to relieve suffering. The apothecaries and surgeons were considered craftsmen rather than gentlemen and were treated accordingly. The physician was a gentleman and his code of ethics which, incidently, did not permit him to sue for default accounts, was much more rigid. In the army and the navy, the surgeon rated with a steward or purser and not in the officer ranks.

THE FIRST SURGEONS

As recorded in F.N.L. Poynter's *"The Journal of James Yonge"*, surgeons did come out to Newfoundland with the fishing fleets in the 17th century and were here for the fishing season only. It is possible that occasionally a surgeon would be left behind accidently or on purpose but it does not seem likely that there were any resident medical men.

The records of the French at Placentia showed that they had a hospital during their stay following 1662. This was probably a room in some building as the term "hospital" was used loosely then, in the sense of a place where a sick or wounded person would be placed rather than a place of treatment. We presume that they may have had a surgeon there.

Our first record, other than that of James Yonge noted above, is of Thomas Adams, appointed surgeon to the Company of Foot in Newfoundland on May 6, 1702. An unnamed surgeon was captured by the French in 1708 when the French attacked St. John's; one Isaac Logoss was appointed surgeon to the militia in the same year, and William Chalmers was appointed surgeon to the Independent Companies in Newfoundland. Later, in 1713, he was surgeon to the Garrison at Placentia. Samuel Moore held the same position from 1713 to 1715 to be followed by James Moore. William Skene, who had been a surgeon to the Garrison at Annapolis Royal in Nova Scotia in 1715, was at Placentia in 1724, later returning to Nova Scotia where he was still active in 1753.

In 1742, surgeon John Monnier was at St. John's as surgeon to the army. He remained until 1762, establishing a farm by Quidi Vidi, which was probably at the site of Pleasantville (Fort Pepperrell). The only medical account we have about him is his testimony at the trial of an Indian girl who died in 1762, along with the statements of two other surgeons. From this it is obvious that the military surgeon served the civilian population as well. A map of St. John's in 1750 shows a Naval Hospital on the Southside. To date, no other records have been found of this establishment.

From 1750 to 1800, the military supplied most of the medical men in Newfoundland. One of these was Thomas Dodd who was at St. John's from 1766 to 1786, when he died. He also served on the Labrador at Fort York in 1776. Intriguing clues about these surgeons can be found in the records but 200 years has obliterated all other trace of them. The appellation of doctor or surgeon was loosely used then and their training was that of apprenticeship. It was very rare to have one who had a university degree unless he was also a clergyman.

In 1784, Johnathan Ogden arrived in Newfoundland having been a surgeon's mate with the army in North America since the beginning of the Revolutionary War in 1776. He later became Chief Justice. Various clergymen acted in a medical, as well as a spiritual advisory capacity. Rev. Dr. Lane was in Trinity in 1765. Dr. John Clinch who had studied under Dr. John Hunter came to Bonavista in 1772 and was probably the first man to use Jenner's new smallpox vaccine in North America; he was later ordained a minister and moved to Trinity. He knew Jenner well and corresponded with him but a letter proving his claim as the first to vaccinate in North America, was lost in the fire of 1892, according to the late Dr. Randall. Jenner's nephew, George Jenner, worked with Dr. Clinch at Trinity. Rev. Dr. Clinch's prominence was such that in 1800 the Governor of the Colony brought him to St. John's to vaccinate the people of Portugal Cove with Dr. McCurdy in attendance.

EARLY HOSPITALS, AND CHOLERA

In 1808, Dr. William Carson arrived in Newfoundland. For the next 30 years, he was a leading light in the medical and political life of the Colony, and due to his interest, a hospital was built in 1813 at the site of Victoria Park. This was to serve the civilian population until 1870. A Military Hospital was located near Government House. This was torn down in 1855 when the military built a new

Military Hospital on Forest Road, part of which still is in use as a section of the General Hospital. A Mental Hospital was built in the 1840's, until a permanent building was located just outside St. John's in 1855, and is still part of the Hospital of Mental and Nervous Diseases.

In 1834, due to the threat of a world-wide cholera epidemic, a quarantine board was set up in St. John's with Drs. Carson, Kieley, Rochfort and Bunting acting on it. Similar boards were formed in Harbour Grace, Carbonear, Twillingate, Trinity, Placentia, Burin, and Ferryland. Preparations for the reception of cholera victims was made at Fort Frederick on the Southside of St. John's Harbour and at the naval stores. From what information is available, the quarantine system was successful and cholera was not introduced into the Colony. Dr. William Carson was requested to prepare a pamphlet to help people prepare for and take care of cholera victims. By 1836, this Quarantine Board's usefulness had diminished and this board became the first Board of Health in Newfoundland with its duties listed to see that the town was clean of refuse, that wells were clean and sanitary facilities were adequate and to vaccinate the population. It appears that the Board's duties fell into default before too long.

In 1854, cholera again appeared in epidemic form but the lessons of 20 years before were forgotten and before effective quarantine measures could be instituted, the presence was felt in St. John's. 212 cases were admitted to the hospital, with a mortality rate of 42%, probably not bad considering the state of the hospital and the lack of any specific treatment. While cholera appeared periodically, it would seem that smallpox was prevalent most of the time. Occasionally typhus would appear and diphtheria was a constant threat. The other illnesses which were treated in the hospital included fevers which were not listed more specifically that this. Rheumatism, gonorrhea, syphilis and always a number with delirium tremens were among other conditions listed. In another field, in 1848, within one year of its introduction, chloroform was used on a surgical patient and was duly reported in the local newspapers.

Since the hospital was established in 1813, it continued to have financial and operational difficulties throughout its existence. It was not until 1871 when the hospital transferred to the Military Hospital and Dr. Crowdy became Superintendent, that it had its first resident medical staff.

OUTPORTS AND THEIR DOCTORS

Medical men had been scattered in various outports. Dr. Lane, as already mentioned, was in Trinity in 1765. Dr. Bradshaw was in Trepassey in 1792 but moved to Placentia where he practiced until 1825. Dr. Dingle, a missionary as well as a doctor, was at Bay Bulls in 1796, where he was captured by the French and taken to St. Pierre. He returned to Bay Bulls to practice there later.

By 1830, there were some 12 medical men scattered around Conception Bay from Brigus to Bay de Verde. Doctors were also listed in Green's Pond, Trinity, Twillingate, Placentia, Fermeuse, and Bonavista. Some were missionary medical men, others had varying qualifications as practitioners. At least four were university trained. There were seven physicians in St. John's, five Edinburgh trained and two naval surgeons. As time passed, more and more trained doctors settled in Newfoundland. In the outports, most were active as magistrates as well as doctors. In St. John's, they served the community well, not only medically but in politics, stimulating agriculture and education.

When the hospital was moved to the Military Hospital at Quidi Vidi (Forest Road), the old hospital was used as a Fever Hospital and was finally burnt down in 1888. St. George's Hospital and the Lazaretto on Signal Hill, both old military buildings, were used as Fever Hospitals until 1892, when St. George's Hospital burnt down in the great fire of that year. A Fever Hospital was constructed on the grounds of the General Hospital on Forest Road in 1902, and this served until 1968 at which time it was turned into special laboratories for Memorial University.

FORMATION OF THE MEDICAL SOCIETY

In 1867, the Medical Society of St. John's was formed, with Dr. Stabb as President and Drs. McKen, Renouf, Bunting, Crowdy, Fraser, Simms and Shea present. It was at this time that they announced that doctors henceforth would be remunerated on a fee-for-service basis (5 shillings per visit except for fishermen and day labourers, who were charged 2 shillings 6 pence). Prior to this time, dating back to Dr. William Carson's day, a person paid a small amount per year for all calls and medicines. The change was hailed as a great step forward and as one editorial of the day said, "it will lessen the unnecessary calls and the thunderings at the physicians' doors." It appears as if the last 100 years has taught us little in medical economics.

By this time, the medical men were respected members of the community. The hospital expanded and new wards were erected. In 1880, an Act was passed requiring compulsory vaccination against smallpox. In 1893, diphtheria antitoxin was used in Newfoundland. In 1896 the first Medical Act came into being, regulating the practice of medicine in Newfoundland. It took into consideration that not all doctors were qualified and one section of the act allowed registration of clergy who made over half their income on medical practice. One such person registered under this section.

In 1896, there were 48 doctors in Newfoundland, 14 in St. John's, the rest being scattered over the Island. Some had come out as medical officers from English companies who still maintained fishing stations here, to the new mines, and as one of the most famous, to help succour the

fishermen both spiritually as well as physically: Dr. Wilfred Grenfell. He established a medical mission among the Labrador fishermen with a base at St. Anthony. His work is perpetuated by the International Grenfell Association.

THE MODERN ERA

Medical science progressed rapidly. Within a year of Roentgen's discovery of the X-ray, it was used clinically here in St. John's. In 1902, Dr. A. Brehm was appointed Medical Health Officer. In 1906, he was responsible for the first Public Health Laboratory in the country. In 1903, the training of nurses was commenced at the General Hospital by Miss Mary Southcott, a "Nightingale" trained nurse from St. Thomas' Hospital, London. At least one Newfoundland doctor, Thomas Anderson, served in the South African War. When the First World War came, 12 Newfoundlanders and possibly more served in the various medical services, as well as many nurses, VADs and ambulance drivers. A sanatorium for tuberculosis was opened in 1917, through efforts to establish sanatorium care similar to that at Lake Saranac in New York had been under way since 1909, when the Association for the Prevention of Consumption was formed. St. Clare's Mercy Hospital opened in 1922 and the Grace Hospital in 1923, to serve the city as private hospitals.

Outside of St. John's, the first hospital to be established on a continuous basis was at the International Grenfell Association at St. Anthony under the direction of Dr. Wilfred Grenfell. Later, hospitals were established by the companies at Grand Falls and at Corner Brook. A Fishermen's Hospital was built at Grand Bank as early as 1909, and following the First World War, the Notre Dame Bay Memorial Hospital was erected at Twillingate. During the Depression, Newfoundland was particularly hard hit. Doctors left some of the outlying areas and were not replaced. It was under these conditions that the Cottage Hospital Scheme was started in 1935 and to date 17 cottage hospitals have been constructed. Since confederation, a new sanatorium was constructed in Corner Brook, which in recent years has been taken over as a general hospital. Both the Grace Hospital and St. Clare's Hospital have extended their facilities and both Gander and Grand Falls have modern well equipped hospitals. A Red Cross Out Post Hospital was built in Carbonear in 1958, serving the Conception Bay and Trinity Bay areas.

An active Clinical Society in St. John's formed the Newfoundland Medical Association in 1923 and held its first convention in 1924 with Dr. L. Keegan as the first President and Dr. Cluny MacPherson as Secretary-Treasurer. In 1949 when the Dominion of Newfoundland entered confederation with Canada, the Newfoundland Medical Association became a Division of the Canadian Medical Association.

The history of Newfoundland Medicine would not be complete without a list of distinguished Newfoundlanders who have served Canadian medicine and the CMA. This would include Sir Thomas Roddick, Dean of McGill Medical School and President of the CMA in 1890 and honoured as an Honorary Member of the CMA in 1912; Dr. Norman Gosse of Halifax, President of the CMA in 1950 and Chairman of the Executive Committee of General Council from 1952-1959; as was Dr. T. Quinton of Sherbrooke, Quebec from 1961 to 1964.

In recent memory, the medical scene in Newfoundland has changed with such rapidity as would have amazed our professional forefathers. The development of the Cottage Hospital system was a brave experiment in social medicine at a time when Newfoundland was in the depth of a world depression; in a country where two-thirds of the population was isolated and transportation was by boat, the difficulty of providing medical services was indeed a major problem. Not only was it necessary to establish cottage hospitals but also to provide medical care brought to the outlying areas by boat. A real change in all facets of life in Newfoundland has been the improvement of the facilities to travel by road or by air. This alone has brought medical services to within hours of most people most of the time. The introduction of specialization following the Second World War changed the pattern of medical care so that today more than one-half the practicing physicians in St. John's are specialists. But above all, the greatest change has been the establishing of the Medical School at Memorial University, with its first Dean a Newfoundlander, Dr. Ian Rusted. It is but a short ten years ago that the Newfoundland Medical Association in its brief to the Royal Commission on Health voiced the hope that a Newfoundland Medical School would be established.

On April 1, 1969, the Medical Care Insurance Act became operative, thus completing full circle the changes to fee-for-service welcomed by the doctors, the people and the press but a short 100 years before.

This brief outline passes lightly over the long history of the medical profession in this province. We know little of the doctors, of the concern they had for their suffering patients and can only guess at their attempts at treating them. It is a brave heritage that we of the medical profession can look back at with pride and look forward with hope of better services to all who come to us. □

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NEWFOUNDLAND: AN HISTORICAL BACKGROUND

A. B. Perlin,*

St. John's, Nfld.

When Newfoundland became a member of the Canadian family on April 1, 1949, the grand design of 1867 was at last completed and Canada became a whole nation. That, she could not have been, so long as the island of Newfoundland and its great Labrador territory maintained an independent existence. Newfoundland stood, up to that time, with her face turned to the British Isles and her back to the Gulf of St. Lawrence whose northern and southern entrances she commanded. Nor was it comforting to Canada to know that the Labrador peninsula, forming the northeastern corner of the continent, belonged to an autonomous member of the Commonwealth with close economic ties with the United States. With this final act of Confederation, Canada gained a new sense of strategic security. With that she acquired another 156,000 square miles of territory, 42,000 sq. m. of which were the area of the island of Newfoundland; 340,000 people (now more than 500,000); a great storehouse of natural resources; and a new beginning for her history.

Since it was the nearest part of North America to Europe, it was natural it should be the first land to the west to be discovered by Europeans. Norsemen from the Greenland colony found it first but their stay was brief. After them by nearly five centuries came sailors from Bristol, possibly ten years before 1497 when John Cabot was given the credit for discovery. But if Newfoundland was brought into the known world by Englishmen and became officially the first British overseas possession when it was visited by Sir Humphrey Gilbert in 1583, it had to wait until 1824 to acquire the status of a colony. It was only then that the British Government ended the fiction of centuries which regarded Newfoundland as a great ship moored on the Grand Banks, serving as a summer station for British fishermen and a training ground for seamen for the Royal Navy. Permanent settlement was subject to severe restrictions and the penalties inflicted on those who made their homes in the island included indifference and neglect.

If the island had not been set down in the midst of the most prolific fisheries in all the world, it might never have been settled at all in an age when colonization was dependent on the ability to live off the land. But salt codfish was a commodity in great demand and became the medium by which the inhabitants of Newfoundland were able to pay for the necessities of life which they had to import. Its history has been that of a coastal people, spread in Newfoundland over a deeply-indented coastline of 6,000 miles and along the bleak coast of Labrador for a thousand miles. Except for the inland mining town of Buchans, almost the entire population of the island of Newfoundland lives on the sea or within a few miles of it. The great land mass of the island is a vast emptiness of forest, marsh, lake and river. That was true also of Labrador until the opening of the iron mines around Lake Wabush in 1959 and the current development of the hydroelectric potential at Churchill Falls which, by 1975, will be sending annually 40,000 million kilowatt hours of energy over one of the world's longest high voltage transmission lines into Quebec and Ontario.

Newfoundland acquired representative government in 1832 and full responsible government in 1855, but its statesmen were preoccupied for a large part of the 19th century with conflict with France over concurrent fishing rights which had been granted more than two centuries before. The extra-territorial claims of the French, finally settled in 1904, deferred development and the fishery was incapable of providing a stable prosperity for a fast-increasing population. But the unequal struggle was fiercely fought; a narrow gauge railway was laid over a circuitous route of 540 miles from east to west coast, and one result was the introduction of modern industry in the form of two large paper mills which have today a combined daily output of 2,000 tons of newsprint.

But there was never enough money to go round and by 1934, in the midst of the great depression of the thirties, the price of financial aid from Great Britain had to be paid in the suspension of self-government and its replacement by an appointed Commission of six, three from England and three from Newfoundland, under the chairmanship of the governor. In that period a reorganization of the public services was undertaken, finance was put on a sound footing, a first-class civil administration was developed, and the foundation of progressive social services was laid. With the establishment of several large American defence bases during the war and a rising world demand for Newfoundland's basic products, prosperity was raised to a new peak and the people were never better off than they were at the time that they voted by a narrow margin to unite with Canada. This was the outcome of a natural restlessness in a political vacuum in which, for fifteen years, there was not even a vestige of elected representative institutions other than the city council of St. John's.

The immediate material gains were derived from inclusion in the Canadian social security system. But the man who had persuaded the majority of the people to vote for confederation with Canada, Joseph R. Smallwood, was

*Editor, Daily News, St. John's, Nfld.

a dynamic leader with a soaring imagination and a determination to transform the new province into a prosperous member of the Canadian family. He was, moreover, under no illusions about the cost of failure. With no barriers to migration to the mainland, he was afraid that there might be a great outflow of people if jobs could not be made at home. With the slogan of "develop or perish" to inspire him, he spearheaded the effort to promote expansion of resource industries and bring new investment capital to the province. With larger contributions of federal funds becoming available in 1959 and by borrowing, he ended the ancient internal isolation with its dependence on sea communications by a network of provincial highways, changed a junior college into a degree-conferring university which has today more than 6,000 students, built modern schools, a complex of vocational colleges, and new regional hospitals. Change was convulsive. It has been reflected in a budget which has soared from a little more than $100 million in 1962 to more than $400 million in 1970. At the same time, he launched the most intensive effort of any province in the search for a stronger industrial base, often at risk, sometimes at the cost of failure, but nevertheless productive of a far more varied economy which has still great expectations to be realized.

Change, that has included larger opportunity for education as well as access to a North American standard of living, has had its impact on every aspect of the Newfoundland society and has bred new aspirations towards social, economic and cultural progress. In all this there is a new Newfoundland which has still deep-rooted pride in its history and traditions and can feel with justice that it is making a full contribution to Canada. Confederation is a two-way street. Its benefits have been substantial but Newfoundland is also pulling its weight as a member of the Canadian family in many ways. Exporting almost all it produces and importing 90 per cent of what it consumes, Newfoundland has enhanced greatly Canada's foreign exchange earnings and her domestic output. It would be wrong to consider confederation in terms of the market place, but a balance sheet in those terms would be convincing evidence that Newfoundland is making a very large contribution to the wealth of Canada. But these things and much more, including the highlights of nearly five centuries of history, cannot be adequately told in a capsule survey. It is hardly even a superficial introduction to a province that is striving to overcome the disadvantages of a checkered past and earn itself a prime place in the great nation to which it entrusted its destiny barely 22 years ago. □

From The Secretary's Desk

Ladies' Hospitality Suite

The Newfoundland Medical Association will have a hospitality suite at the CMA Convention in the Hotel Nova Scotian, Halifax. Wives of the doctors from Newfoundland will be the hostesses at this hospitality suite.

Newfoundland Night – Wednesday, June 9

There will be a dinner and dance held in Newfoundland tradition. The dance will be a good old Newfoundland Scuff with Newfoundland music predominating. The event will be open to all members of the Newfoundland Delegation attending the Convention and also for any Newfoundlanders who might be living and practicing on the Mainland. The cost of the dinner and dance will be $10.00 per head; and because of the limited number of tickets available, if anyone would care to reserve a ticket, it is suggested that they write to Mr. G. F. Lynch, Executive Secretary, Newfoundland Medical Association, O'Mara-Martin Building, Rawlins Cross, St. John's, Newfoundland.

A chartered flight to Halifax

The Newfoundland Medical Association have arranged for two aircraft to take delegates from St. John's to Halifax on June 6. The first is a DC 9, leaving at 7:30 a.m., Sunday Morning. The second is a DC 8, leaving at 2:30 p.m., Sunday Afternoon.

The Newfoundland Medical Association are offering a package deal for the CMA Convention. This package deal includes: –

1. Two tickets for formal dinner and dance on Saturday, June 5.
2. Air fare to Halifax and return.
3. Registration to CMA.
4. Two tickets for Newfoundland Night – dinner and dance on Wednesday, June 9,

The cost of a package deal for a single doctor is $136.00; for a doctor and his wife, it would be $225.00.

If interested, please advise the NMA Office immediately.

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THE INTERNATIONAL GRENFELL ASSOCIATION IN THE NORTH

W. A. Paddon, M.D.,

North West River, Nfld.

The Grenfell Association is a voluntary medical and social service which serves the entire coast of Labrador and all of the Great Northern Peninsula of Newfoundland. It was founded by Sir Wilfred Grenfell in the late 19th century. It operates a Regional Hospital of nearly 200 beds, at St. Anthony, and cottage hospitals at Harrington, Quebec, North West River, Happy Valley and Churchill Falls, and a number of nursing stations.

These dull statistics fail to do justice to an extremely unusual and highly developed frontier medical service. In existence for three-quarters of a century, the organization has learnt, often the hard way, a great deal about climatic adaptation, the sea, aircraft and their various capabilities and shortcomings, Eskimos, Indians, settlers of all varieties, military establishments and many other varied subjects.

The area, which serves nearly 50,000 people, is enormous and the population very thinly scattered: there are about two and one-half square miles of territory for each person. The climate is severe, with a long cold winter and a short and frequently lovely summer. Terrain varies from glaciated bare rock in the far north, in majestic fjiords rivalling the finest in Norway, to vast spruce forests and innumerable lakes and rivers in the interior, some of them vary large. The Churchill River, which empties into Lake Melville, is one of the larger ones flowing into the Western Atlantic; its gigantic hydroelectric project two hundred and fifty miles inland has employed up to 5000 men during the past five years and will be completed next year, to produce seven million horsepower, thereby eliminating a waterfall twice as high as Niagra and nearly as big. And in Churchill township you will find the Grenfell people, even as you will in the remotest northern Eskimo community of Nain with nearly 800 Eskimos and a trim little nursing hospital with two nurse-midwives coping with whatever turns up. Indeed the Nursing Physician Associate of whom we hear so much now was virtually invented by the Grenfell Mission and raised to a remarkable level of efficiency.

THE HEADQUARTERS AT ST. ANTHONY

St. Anthony, a trim little town of some 2,000 is the headquarters of our operations, and there Dr. Gordon Thomas, once of Toronto, is our Executive Director and also a general surgeon of versatility and experience who did some 2000 open chest operations during the years we fought a pitched battle with tuberculosis and for a time nearly lost it. The new hospital is a perfect gem, modern as anything in the land, and the doctors have well subsidized and attractive homes provided for them. The staff includes a surgeon, in addition to Dr. Thomas's own formidable talents, a gynaecologist-obstetrician, an internist, a paediatrician, an anaesthetist, a radiologist, a pathologist, a psychiatrist and various travelling doctors, and residents. It is fully accredited and affiliated with the medical school at the University in St. John's, the provincial capital. The Organization is controlled by radio telephone, and our three aircraft, the four hospitals, fourteen nursing hospitals, our hospital ship and various other installations talk daily by RT on schedule. It is one of the first things you will learn to do if you should throw in your lot with us. Contracts are usually for a year or more and although incomes are below those of gross Medicare earnings the various benefits included tend to offset this. At St. Anthony there is a twin-engined aircraft of our own for executive and inter-airport flying, and a turbo-prop Beaver of incredible versatility which skips in and out of minute harbours, off frozen ponds or marshes and wherever there is a few hundred feet of space.

RURAL LIFE, TOTAL MEDICINE

At the upper end of Lake Melville there are two hospitals of widely different functions. One, at Happy Valley, is a handsome small town hospital of about 25 beds, and as modern as tomorrow. It serves about 12,000 people around the Goose Airport area, and in the town of Happy Valley. A new wood pulp industry has just increased the work-load, and will shortly increase the staff and the plant.

North West River, the writer's own love, 25 miles from Happy Valley, is a town of one thousand inhabitants lying along both sides of a broad swift river. The South side is primarily Indian, the North side mostly settler, with some Eskimos. The village is heavily wooded, very beautiful, and with a delightful and leisurely cordiality that marks most Northern settlements. The hospital, 50 beds, is well equipped and comfortable, totally integrated racially, good-natured and down to earth. It can manage its own emergency surgery but major elective surgical cases go to St. Anthony. It too has its own Beaver, a veteran piston engined one, but sturdy and reliable, and this 'plane flies 1000 hours yearly to the outlying villages, including three large Eskimo towns northwards and one Nascopi Indian resettlement project at Davis Inlet. The staff complement is three doctors. Much tuberculosis is still treated here and patients come in and out in droves whenever the flying conditions are good, for their periodic reviews. Tuberculosis produces less and less morbibity and really no mortality

and the end of this nuisance is in sight. Likewise acute cases, abdominal problems and fractures appear regularly, and the work is varied and rewarding. Much responsibility rests with the doctor, and it is one of the few backwaters where one can still practice total medicine, with all that this entails.

The Eskimo and Indian patients are probably the most appreciative in the world, a pleasant and dignified people who mix contentedly in the hospital or clinic, and the word 'thank you', in three languages, is heard more often than is usual in city hospitals.

The nursing stations are in the hands of capable nurse-midwives. These girls, either British or trained in the Dalhousie School of Frontier Nursing, are as capable a lot as you will find anywhere in the world. Some of my stations, in the past two years, have dealt with such problems as eclampsia, urinary obstruction (by suprapubic cystostomy) fractures of a surprising variety, gunshots, maniacal patients, and suicidal poisoning, often where bad weather prevented flying, until well after the crises was over. The nurse has radio telephone contact, but beyond that has only her own presence of mind and skill. Alcohol is a tragic problem in the North amongst what would otherwise surely be amongst the gentlest and kindest people on earth, and sometimes crimes of violence occur. One nurse and her station maintenance man discovered a drunken fight one night in which a son-in-law murdered his wife's father with a rifle and then turned his attention to the spectators of this hideous event. Our man, despite being fired at, managed to help disarm the wildly excited Eskimo while the nurse did her best to staunch the fatal haemorrhage in the murdered man. Mercifully the drunk usually settles for making a nuisance of himself although black eyes and minor fractures accompany many of the bottle parties, and we have one quadriplegic whose neck was broken in what must have been one of the worst of all such sprees.

The Labrador people in general are quiet, solid and fond of their stern and extraordinarily lovely land, and when good educational facilities are provided remarkable talent turns up in unexpected places. At North West River we operate a boarding school for 75, shortly to be enlarged to 130, and the brighter youngsters from five hundred miles of coast come here of their own volition to obtain the high school which is rarely available in their own villages. We have many other activities, as an organization, and these include handicrafts, rehabilitation, social development, and generally efforts to encourage self-sufficiency.

Our southernmost hospital is in Quebec, at Harrington Harbour, and this is the only station which might call for a bilingual doctor. About 40 beds in size, the hospital was for many years the child of Dr. Donald Hodd, now retired, and serves an English language block along a French coast. This is a fishing and seal-hunting population, on a rocky but fascinating coast, and here the doctor is wholly on his own.

The work of the Grenfell Association should attract more doctors from Canada, itself. It is stimulating, satisfying, and something truly off the beaten track. Equipment and resources are good, and the widespread organization is remarkably cohesive and close knit. In three-quarters of a century it has learnt much of the wilderness and its people, and most of us develop a love of both which gives purpose and satisfaction to life. □

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THE COTTAGE HOSPITAL SYSTEM IN NEWFOUNDLAND

D. Cant, M.B., F.A.C.S,*

St. John's, Nfld.

During the First World War and immediately afterwards, the economy of Newfoundland was experiencing the bracing effects of the spending which always accompanies a worldwide war. At this time the outports of Newfoundland were served by a number of private practitioners who gave service to the public which was, by the standards of the times, very good. While their standard of living was not particularly high, they were at least able to make a living. There was a great shortage of hospital beds, except in some of the larger towns, and the most striking feature of the country was the isolation suffered by most of the settlements which were scattered around the shoreline. Roads for the most part were non-existent outside the Avalon Peninsula and, indeed, it is only since 1966 that a completely paved highway traverses the island from east to west.

EFFECTS OF THE DEPRESSION IN NEWFOUNDLAND

Following the economic buoyancy experienced during the war came the Depression which reached into the dismal days of the 1930's when all aspects of Newfoundland life became involved, with disastrous effects on the economy of Newfoundland and the day-to-day lives of all its citizens. The few general practitioners in the outports who had previously managed to keep body and soul together were forced to leave their practices, and it became obvious, when the Commission of Government took over the reins of power, that some government-assisted health scheme would have to be devised to meet the basic requirements of the health of the people.

Doctor H. M. Mosdell, who was the Secretary for Public Health and Welfare, and some of his associates looked around to find out what had been done in comparable geographical situations elsewhere in the world. The area most like Newfoundland where a government scheme had been worked out was on the west coast of Scotland; the Highlands and Islands Health Scheme served the needs of a population very similar to that of Newfoundland, scattered in villages, where the main source of livelihood was fishing and marginal farming. It was on this model that the Cottage Hospital System in Newfoundland was based.

The idea was that the island would be divided into a number of districts wherein would be built a Cottage Hospital, having from 15 to 30 beds and which would serve as the headquarters of a doctor. He would be responsible for looking after the Cottage Hospital District. These districts varied in size. In some of the larger districts, there would be district nurses who would look after the day-to-day care of their own particular nursing district, and they would be responsible for referring more complicated cases to the doctor situated at the cottage hospital. In some cases, the doctor from the cottage hospital made periodic trips around the district to visit the district nurses.

The doctors received a salary from the Department of Health and several different schemes were devised to augment their salary. In some cases, the doctor was given a proportion of the medical fees collected and in other cases, he was paid special fees for certain types of service. For a long time prior to the scheme, doctors in Newfoundland had treated patients on the basis of a yearly capitation fee which was enough to get the patients on the doctors' "books". This capitation fee was enough to give the doctor a basic salary and any special services required would be paid for in cash or in kind.

Following this principle, the families in the cottage hospital area would subscribe to the Cottage Hospital Scheme paying a yearly fee, which varied over the years, but when it began was $2.50 a year for the whole family. This included all medical attention, hospitalization in the cottage hospital, any surgical procedures which were required as well as the medical costs of being referred to a larger hospital in St. John's, or even out of the country if complicated treatment was required which was not available in Newfoundland.

Other things which had to be paid for were drugs, but these were sold a purely nominal sum. Maternity cases were paid for extra, as were dental extractions, at one time the charge being 25c for the first tooth and 5c for every additional tooth.

The families under the scheme were supposed to have paid their fee by a certain month of each year. Those not paying the fee by the time it should have been paid were charged an extra fee for late payment.

During the first few years of the scheme very often fees were paid in quintals of fish or bags of potatoes or other produce when money was scarce. An interesting figure in the background of all of these proposals was that of Mr. H. J. A. McDermott who lived in Poole's Cove, Fortune Bay, and who combined the offices of clergyman, magistrate and doctor. It was he who with others helped to inaugurate the Cottage Hospital Scheme by the acquisition of the motor vessel *Lady Anderson* in July 1935. This vessel was intended to serve the south coast; this area had

*Assistant Deputy Minister of Health, Newfoundland.

long suffered from the lack of medical services except for the hospital at Grand Bank, which had been open for some years due to the initiative of the local residents of that town. The first medical officer on the *Lady Anderson* was Doctor Nigel Rusted.

THE FIRST COTTAGE HOSPITALS

By 1936 the first cottage hospital had been opened at Old Perlican and during the next few years from 1936 to 1942, 14 cottage hospitals or nursing stations had been completed and put into service. Until some time after Confederation, the only means of communication in most of the outlying parts of the Island was the telegraph office. This was operated in association with the post offices and had a system of priorities. A pink telegram, whick cost extra, was speedier than a white telegram, which was sent at a cheaper rate. The time at which the telegrams could be sent depended on the hours during which the post offices were open. Road communications were primitive or non-existent and until the post-war era very little air transportation was available for use in emergencies.

This state of affairs required a type of doctor who was self-reliant and prepared to handle almost anything that came his way. Elective surgery and complicated medical cases could be referred to St. John's, but this necessitated a trip on the coastal boat whose timetable depended on the vagaries of the wind and weather and in more northern communities would be unavailable during the winter months.

During the first two decades of the service, infectious diseases played a very large part in the day-to-day practice. Diphtheria was an ever present possibility and was a cause for much worry in the case of the isolated practitioner. During the first years of the cottage hospitals, it was rarely that more than one doctor was stationed at a hospital. This lack of ability to consult with colleagues was a grave disadvantage compared with the present day situation where no hospital is without at least two medical officers. Poliomyelitis was another hazard which was an ever present possibility in diagnosis, until Salk vaccine became available as late as 1955. Of all the infectious diseases, however, the prime place must be given to tuberculosis. The living conditions in some of the settlements, with overcrowding and malnutrition, were in some cases indescribable. It was not very uncommon to find a house, small and miserable by any standards, where maybe anywhere up to four or five persons would be bedridden with tuberculosis. While accommodation at the Sanatorium in St. John's was available, it was exceedingly difficult to get cases admitted because of the pressure on the beds. Tuberculous meningitis was a frequent cause of death amongst babies; in the era before streptomycin it was a hopeless condition and the cause of much suffering and misery.

Immediately before the war and during its first year or two, while sulfonamides were being developed, it was very difficult to get supplies, and whooping cough created grave problems amongst infants and young children. In certain parts of the Island, notably on the west coast, venereal disease, especially syphilis, was endemic and the arrival of the construction workers and the men involved in building and manning the base at Harmon Field caused considerable aggravation of the problem. This was before penicillin was available to civilians, and treatment with intravenous arsenicals and intramuscular bismuth took up much of the time of the health personnel in this area.

In almost all outports electricity was completely unavailable. Anyone lucky enough to own a radio worked it by means of a dry cell for high tension power and a wet cell. The wet cell was often charged by a wind charger and the wind chargers scattered around the settlement were a noticeable feature of the landscape in many places. Cottage hospitals, being government institutions, were painted the peculiar yellow with green trim, which was also reserved for other government premises such as those housing the magistrate and the Rangers.

In order to provide electricity for the cottage hospitals, most were equipped with a 'delco'. At first these supplied electricity on demand when the light switch was activated, and at all hours of the day and night, when electricity was needed, the noise of the 'delco' switching on and off frequently shattered the rural quiet. Later a system of wet cells was developed, and the 'delco' was run at certain times of the day to charge the batteries which were then available during the night and made it unnecessary to run the noisy machine. These batteries were large wet storage cells, situated usually in a small outhouse at some distance from the main hospital building and arranged in tiers on wooden benches. Usually somewhere alongside was a small cabin which served as a mortuary. Because the wet cells produced hydrogen during their charging, they presented something of a hazard to the unwary and on more than one occasion, these heavy glass cells exploded and shards of glass penetrated the walls of the battery house. Fortunately, there is no recorded instance of any serious injury.

POST-WAR PROGRESS

At the end of the war, the program continued and in several places hospitals previously serving the purposes of the military were taken over: Botwood and Gander are cases in point. These were only temporary buildings but continued to serve their purpose, Botwood to this day, and Gander until the magnificent new hospital was completed in 1963. This was named after Doctor James Paton who had spent his life since 1937, first of all in Harbour Breton, then in Placentia and finally at Gander, working in the Cottage Hospital System. Unfortunately, he died before he could see it completed. He holds a special place in the memories of all who came into contact with him while working in the Cottage Hospital System. Coming from

(continued on page 23)

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Northern Ireland after his medical education in Edinburgh, his sense of humour and ability to deal with patients in the most awkward conditions endeared him to the hearts of many in all the areas in which he practiced.

In the 1950s hospitals were completed at Channel, Fogo and Springdale, and in 1954 the Department of Health took over as a cottage hospital the hospital at St. Lawrence which had been built by the United States government in recognition of the services given by the people of St. Lawrence and Lawn during the shipwrecks which involved the U.S.S. Truxton and the U.S.S. Pollux.

In the early days almost all cottage hospitals were run singlehanded by the medical officer in charge who relied to a great degree on the assistance of his nurse in charge. She filled many functions which today would strike horror into the more and more highly professional nursing practitioners. Both the nurse in charge in the cottage hospital and the nurses in the districts performed the duties which are now being talked of in terms of feldshers, physician's assistants and the like. Many of them were generally trained nurses with midwifery certificates from the United Kingdom, and no doctor who worked with them needs to have any research model to be able to say without any hesitation that they filled the bill of medical auxiliaries with great ability and enabled the scattered doctors to deliver medical services of excellent quality to a scattered population, who otherwise would have had no services at all.

As time has progressed communications in the rural areas of Newfoundland have improved considerably. Roads now run between settlements where no one ever dreamed they would, and airplanes and helicopters have become everyday means of transport. No cottage hospital now is staffed with but a single medical officer and many have more than two, depending on their size. This means the doctor is no longer on call 24 hours a day, and in some of the larger institutions, the hours of work would compare more than favourably with the average private group practice. Remuneration has improved and together with the fringe benefits, such as subsidized housing and the lack of overheads in practice, make the Cottage Hospital Scheme an attractive proposition. At the end of it, there is now a pension which is a matter of right rather than a matter of *ex gratia* payment which it was in the past.

THE FUTURE

The future of the Cottage Hospital System depends on the future of medicine, and with the disappearance of isolation there is less and less excuse for having small hospitals in scattered areas, rather than larger hospitals with more equipment and a more highly skilled staff who are all together in one place available for consultation one with the other. As communications improve further, it is most likely that many cottage hospitals will be changed into community clinics with facilities for simple laboratory and x-ray studies and that the doctors will have with them public health nurses and more time will be devoted to public health measures. The seriously ill patients will be taken to bigger centres for more specialized and complicated forms of treatment. Nevertheless, the system today offers opportunities and experiences which it would be difficult to find elsewhere in the western world.

For anyone wishing to have a stimulating experience in general practice, yet not in isolation as a rule, the cottage hospital provides ample clinical material and much satisfaction as well as a good financial reward and many of the benefits above, including a month's study leave after a year of satisfactory service. Even if the medical man's eventual goal is to enter a specialty, the grounding in general practice will stand him in good stead and make him a better balanced doctor in whatever field he enters in the future.

In conclusion, it is impossible to mention anything about cottage hospitals in Newfoundland without identifying a number of individuals whose labours over the years have contributed to its great success. At the beginning Sir John Puddester, the Commissioner for Public Health and Welfare and Doctor H. M. Mosdell had the vision to conceive the scheme. Their efforts were ably continued over the years by Doctor Leonard A. Miller, the Deputy Minister of Health, whose stature in the field of Public Health is recognized everywhere, together with Doctor James McGrath who was at first the Assistant Deputy Minister, later having a long tenure of office as the Minister of Health.

For solving the particular problems of the Newfoundland outports, the Cottage Hospital System must be credited with a great degree of success, and the health and lives of many of the people in the outports would be very different today if this far reaching and forward looking scheme had not been introduced over 36 years ago. □

The general hospital in Poole, England, has a truly eminent surgical staff. That's the view of one patient, anyhow – a small boy whose post-op conversation with his mother was reported by the hospital's newsletter: "It was God who took out my tonsils," he told her. "When I was taken into the big white room, there were two lady angels dressed in white. Then two men angels came in. Then God came in." "How did you know it was God?" asked the mother. "Well, one of the men angels made me open my mouth and looked down my throat and said, 'God, look at this child's tonsils.' Then God took a look and said, 'I'll take them out at once.'" □

—Ontario Medical Review

From The Secretary's Desk

Board of Directors Visit to St. John's – June 3 to June 5

The CMA Board of Directors will be visiting St. John's and holding a series of meetings from June 3 to June 5.

On Friday evening, 4th. of June, the Board of Directors and the Executive of the Newfoundland Medical Association and their wives will have a dinner at the Starboard Quarter in St. John's, Newfoundland. The Starboard Quarter is located in the Royal Trust Building, and it overlooks the very scenic St. John's Harbour.

A President's Reception – a formal dinner and dance will be held for the Board Members and will be open to all members of the Newfoundland Medical Association on Saturday, June 5. This formal dinner will take place at Hotel Newfoundland.

NMA Convention – October 27 to October 30

The Newfoundland Medical Association have changed the date of their Convention. The Convention is usually held in the Spring; however, to avoid conflicting with the CMA Convention, this year the Executive decided to move the NMA Convention to the Fall. The Fall Convention will be held in co-operation with the Continuing Medical Education Office, who normally run a Fall Refresher Course. The Continuing Medical Education Office will be looking after the Scientific content for the Convention.

THE 6th. CANADIAN CONGRESS OF NEUROLOGICAL SCIENCES

WELCOME

The 6th. Canadian Congress of Neurological Sciences will be held in St. John's, June 16 – June 19, Hotel Newfoundland.

For further information, write to Dr. A. M. House, c/o Continuing Medical Education Office, Memorial University, St. John's, Newfoundland

CANADIAN DERMATOLOGICAL ASSOCIATION CONVENTION

DERMATOLOGISTS WELCOME

The Canadian Dermatological Association Convention is to be held at Holiday Inn, St. John's, Newfoundland, from July 9 to July 13, 1971. All are welcome.

Further information may be obtained by writing to Dr. J. Barrie Ross, President, CDA, 220 LeMarchant Road, St. John's, Newfoundland.

PRODUCTS FOR RESEARCH PURPOSES

In the course of research activities and the development of new preparations in the Connaught Medical Research Laboratories, it sometimes happens that materials of scientific interest for research purposes become available. Some materials at present available, in some instances in only very small amounts, are the following:

Normal Serum Albumin—Human (Dry powder or solution)

Immune Serum Globulin—Human (Gamma globulin)

Fibrinogen—Human

Caeruloplasmin—Human

Antihaemophilic Globulin—Human

Fractions of Plasma—Human (Various fractions produced by Cohn cold ethanol process)

Insulin—Human (Carefully standardised ampoules containing 0.69 int. units)

Insulin—of Monkey or Horse origin

Tubercle Bacillus—Killed (For the preparation of complete Freund's adjuvant)

Complete Freund Adjuvant

Incomplete Freund Adjuvant

None of the above preparations is suitable for human use. The Laboratories would welcome inquiries from qualified research personnel or laboratories and will be glad to supply prices for specified items on request.

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CANADIAN MEDICAL ASSOCIATION
104th Annual Meeting

Nova Scotian & Lord Nelson Hotels
Halifax, N. S.

June 6 – 12, 1971

CONVENTION INFORMATION

24-Hour Telephone Answering and
Message Service
Courtesy – TAS
Communications Services
Telephone (902) 423-9131

HOUSING and REGISTRATION –
Mr. R. A. Davis

C.M.A. OFFICE – Lord Nelson
Tel. (902) 423-9131
Mr. D. A. Geekie
Miss D. Oikawa

C.M.A. PRESS ROOM – Lord Nelson
Tel. (902) 422-8561
Mr. D. Baird
Miss H. Otto

C.M.A. OFFICE & PRESS ROOM – Nova Scotian
Tel. (902) 423-9131
Mr. P. O'Brien
Miss M. E. Scrivens

COMMERCIAL EXHIBITS – Nova Scotian, Convention Floor, Atlantic Room
Mr. C. Goodman

SCIENTIFIC EXHIBITS – Nova Scotian, Convention Floor, Terrace
Dr. F. A. Davis

SCIENTIFIC PROGRAM INFORMATION –
Tel. (902) 423-9131
Dr. L. C. Steeves

Mrs. Mary Woodbury, Chairman of the Ladies Committee of the 1971 Canadian Medical Association Convention flanked by Mrs. Marion Anderson, Co-Chairman (left) and Mrs. Shelia Nicholas Chairman of Entertainment. The Honorary Chairman of the committee is Mrs. Catherine Roberts, wife of CMA President Elect Dr. H. D. Roberts.

Dr. W. D. Parsons
President, Newfoundland Medical Association

Dr. O. L. Kippen
President CMA

Dr. J. F. L. Woodbury, President
Medical Society of Nova Scotia

Dr. H. D. Roberts
President Elect CMA

SUNDAY, JUNE 6

CMA and Council

2.00 p.m. –
C.M.A. Convention Office
Lord Nelson, Salon No. 5

3.00 p.m. – 10.00 p.m.
Registration – General Council
Lord Nelson, Mezzanine Floor, Georgian Lounge

8.00 p.m.
Pre-General Council Press Conference
Lord Nelson, Salon No. 4

Social Events

7.30 p.m. – 10.00 p.m.
Welcoming Reception
Host: FMWC
Sir Charles Tupper Building, Penthouse

Ladies' Program

3.00 p.m. – 7.00 p.m.
Registration
Lord Nelson, Mezzanine Floor, Georgian Lounge

7.30 p.m.
Reception: Federation of Medical Women of Canada –
Sir Charles Tupper Building

LADIES PROGRAM

The local Ladies' Committee extends a cordial invitation to all delegates' wives and their children to join in the host of activities planned for diversion and enjoyment during the 104th Annual Meeting of the C.M.A. in Halifax, June 6-10, 1971.

Halifax combines the invigorating atmosphere of a summer sea resort with the old-time charm of a city which can look back at a 200-year history. The visitor on the prowl would certainly find a multitude of things to do. However, "the difficulty in life is choice" and to facilitate this task the Ladies' Committee, under the chairmanship of Mrs. J. F. L. Woodbury, has made a few selections for you in an attempt to show you the real side of Halifax and its surroundings.

Information on sitter service for children age five years and up will be available.

The program will be opened with a welcoming reception on Sunday, June 6, 1971.

LADIES' COMMITTEE

Honorary Chairman, Mrs. H. D. Roberts

Chairman, Mrs. J. F. L. Woodbury

Co-Chairman, Mrs. R. N. Anderson

Secretaries, Mrs. A. J. McLeod
Mrs. L. MacNeill

Treasurer, Mrs. C. B. Stewart

Registration, Mrs. B. Chandler
Mrs. B. Auld

Entertainment, Mrs. Wm. Nicholas
Mrs. G. Bethune

Publicity, Mrs. R. Goldbloom

Transportation, Mrs. E. Pollett
Mrs. D. F. Smith

Youth Activities, Mrs. L. C. Steeves
Mrs. H. I. MacGregor

Hospitality, Mrs. C. L. Gosse
Mrs. G. MacKinnon

Information and Shopping, Mrs. E. F. Ross
Mrs. T. M. F. Roberts

Kits, Mrs. D. R. S. Howell
Mrs. P. Jardine

Flowers, Mrs. H. C. Still

Programs and Tickets, Mrs. F. Hand
Mrs. M. D. Brennan

MONDAY, JUNE 7

CMA and Council

8.00 a.m. – 5.00 p.m.
Registration – General Council
Lord Nelson, Georgian Lounge

9.00 a.m. – 5.00 p.m.
General Council
Ceremonial Opening and Meeting
Lord Nelson, Imperial Ballroom

9.00 a.m. – 5.00 p.m.
C.M.A. Convention Office
Lord Nelson, Salon No. 5

9.00 a.m. – 5.00 p.m.
Press Room A
Lord Nelson, Salon No. 4

12.30 p.m.
Luncheon to General Council
– Installation of President of FMWC
– Presidential Address
Lord Nelson, Regency Ball Room

2.30 p.m. – 5.00 p.m.
General Council
Lord Nelson, Imperial Ball Room

5.15 p.m.
CMA Nomination Committee
Lord Nelson, Salon No. 1

Miscellaneous Events

9.00 a.m.
FMWC Annual Meeting
Nova Scotian, Bedford Room

9.00 a.m. – 5.00 p.m.
Canadian Academy of Sports Medicine
Annual Meeting
Nova Scotian, Fundy Room

9.00 a.m. – 5.30 p.m.
Exhibits Open
Nova Scotian, Convention Floor, Atlantic Room

9.00 a.m. – 5.00 p.m.
Horner Art Salon
Nova Scotian, Convention Floor

Scientific Program

12.00 noon – 9.00 p.m.
Registration – Scientific Program
Nova Scotian, Convention Floor

Social Program

6.30 p.m. for 7.30 p.m.
Reception and Dinner to General Council
Nova Scotian, Commonwealth Room
Host: Government of Newfoundland
Guest Speaker: Premier J. Smallwood

Ladies' Program

9.30 a.m. – 12.00 noon
Registration
Lord Nelson, Georgian Lounge

11.00 a.m.
Sherry at Government House – historic residence of the Lieut. Governor of Nova Scotia
The Hon. Victor deB. and Mrs. Oland
(Tickets at Registration Desk)

12.00 noon – 4.00 p.m.
Hospitality Suite
Hotel Nova Scotian Chart Room

2.00 p.m. – 4.00 p.m.
Registration
Nova Scotian, Chart Room

2.00 p.m.
Art Galleries Visit with a "maritime flavour"
Buses leave Hotel Nova Scotian
(Limited Tickets at Registration Desk)

6.30 p.m.
Dinner to General Council
Nova Scotian, Commonwealth Room
Host: Government of Newfoundland
Speaker: Premier J. Smallwood
Black Tie

Youth Program

2.30 – 4.00 p.m.
Tour of Halifax

6.30 – 9.30 p.m.
"At Home" – for Teenagers
1919 Bloomingdale Terrace

TUESDAY, JUNE 8

CMA and Council

9.00 a.m. – 5.00 p.m.
Registration – General Council
Lord Nelson, Georgian Lounge

8.30 a.m. – 5.00 p.m.
Press Room B
Nova Scotian, Northumberland Room

11.00 a.m. – 5.00 p.m.
Press Room A
Lord Nelson, Salon No. 4

11.00 a.m. – 5.00 p.m.
C.M.A. Convention Office
Lord Nelson, Salon No. 5

1.30 p.m. – 5.00 p.m.
General Council
Lord Nelson, Imperial Ball Room

3.00 p.m.
Open General Meeting
Lord Nelson, Imperial Ball Room

8.00 p.m.
– Installation of C.M.A. & N.M.A. Presidents
– Presentation of Awards & Senior Memberships
Dalhousie Centre for Performing Arts

Scientific Program

Nova Scotian, Commonwealth Room

8.15 a.m. – 5.00 p.m.
Registration
Nova Scotian, Convention Floor

8.30 a.m. – 1.00 p.m.
ADVERSE DRUG REACTION
Chairman: Dr. J. E. MacDonnell

Principal Discussants:

Dr. D. R. Laurence, London, England
Dr. J. Ruedy, Montreal
Dr. D. K. Ford, Vancouver

Subjects & Case Presentors:

1. *Small Bowel Obstruction Due to Anti-Cholinergic Drugs* – Dr. J. C. Spears, Toronto
2. *Congenital Malformations & Drug "X"* – Dr. D. C. Patterson, Kamloops
3. *Variability of NPH Insulin Preparations* – Dr. M. M. Belmonte, Montreal

Miscellaneous Events

9.00 a.m. – 5.00 p.m.
Exhibits Open
Nova Scotian, Convention Floor, Atlantic Room

9.00 a.m. – 5.00 p.m.
Horner Art Salon
Nova Scotian, Convention Floor

10.30 a.m.
C.M.A. Affiliate Societies' Meeting
Nova Scotian, Bedford Room

11.45 a.m.
C.M.A. Affiliate Societies Luncheon
Nova Scotian, Fundy Room

Social Program

10.00 p.m.
Presidential Reception, Buffet & Ball
Dalhousie Students Union Building

Ladies' Program

9.00 – 4.00 p.m.
Coffee and light refreshments will be served in the Hospitality Suite
Hotel Nova Scotian Chart Room

9.30 – 4.00 p.m.
Registration
Hotel Nova Scotian Chart Room

10.30 a.m.
Get-acquainted Coffee Parties of Small Groups in Private Homes
Private Cars will leave from Hotel Nova Scotian *10.15 a.m.*
(Tickets at Registration Desk)

Afternoon Free
(Information available on Tour of City and Bluenose Water Tours).

8.00 p.m.
Annual General Meeting
Dalhousie Centre for Performing Arts
– Installation of CMA & NMA Presidents
– Presentation of Awards & Senior Memberships

– Presidential Reception, Buffet and Ball
Black Tie
Dalhousie Students Union Building
Music by Erno Reti
Entertainment – The Sanderlings

Youth Program

9.30 a.m. – 4.00 p.m.
– Puppet Show by the Junior League of Halifax, Handcraft and Games
Fort Massey Church Hall

Lunch, Swimming, Tennis and other Games
Waegwoltic Club

(Alternate program if raining:)
Tour of Halifax Citadel

6.30 p.m.
International Prize Winning Films by Margaret Perry
(Parents are Welcome)
Nova Scotian Harbour Suite

8.00 p.m.
Games, Music and Dancing for Teenagers
Nova Scotian Harbour Suite

WEDNESDAY, JUNE 9

CMA and Council

9.00 a.m. – 5.00 p.m.
Registration – General Council
Lord Nelson, Georgian Lounge

8.30 a.m. – 5.00 p.m.
Press Room B
Nova Scotian, Northumberland Room

11.00 a.m. – 5.00 p.m.
Press Room A
Lord Nelson, Salon No. 4

11.00 a.m. – 5.00 p.m.
C.M.A. Convention Office
Lord Nelson, Salon No. 5

1.30 p.m. – 5.00 p.m.
General Council
Lord Nelson, Imperial Ball Room

Miscellaneous Events

9.00 a.m.
Secretaries' Conference
Nova Scotian, Bedford Room

9.00 a.m.
Canadian Psychiatric Association
Exhibit Set-up

9.00 a.m. – 5.00 p.m.
Canadian Psychiatric Association
Board of Directors Meeting
Lord Nelson, Regency Ball Room

9.00 a.m. – 5.00 p.m.
Horner Art Salon
Nova Scotian, Convention Floor

9.00 a.m. – 5.30 p.m.
Exhibits Open
Nova Scotian, Convention Floor, Atlantic Room

10.00 a.m.
C.M.P.A. Annual Meeting
Nova Scotian, Fundy Room

2.00 p.m. – 5.00 p.m.
Canadian Thoracic Society Scientific Meeting
Nova Scotian, Fundy Room

Scientific Program

Nova Scotian, Commonwealth Room

8.15 a.m. – 5.00 p.m.
Registration
Nova Scotian, Convention Floor

8.30 a.m. – 1.00 p.m.
NEUROLOGY & NEUROSURGERY
Chairman: Dr. L. P. Heffernan

Principal Discussants:

Dr. J. N. Walton, Newcastle-upon-Tyne, England
Dr. C. Bertrand, Montreal
Dr. T. J. Murray, Halifax

Case Presentors:

Dr. T. J. Quintin, Sherbrooke
Dr. M. P. Quigley, Amherst
Dr. W. J. Stein, Stephenville

Ladies' Program

9.00 a.m. – 4.00 p.m.
Hospitality Suite,
Nova Scotian, Chart Room

9.30 a.m. – 4.00 p.m.
Registration

9.30 a.m.
Tour of H.M.C.S. Dockyard with visits to a hydrofoil – coffee on board a destroyer. (Limited tickets available for husbands, wives and children)
Buses leave Hotel Nova Scotian at *9.15 a.m.*

2.00 p.m.
Bluenose Water Tours of Northwest Arm and Halifax Harbour – 2 hours in a comfortable motor launch. Buses leave Hotel Nova Scotian at *1.45 p.m.*

or

10.00 a.m. – 12.00
and
2.00 – 4.00 p.m.
Coffee and Hospitality at Bridge at "The Oaks" – former residence of Robert L. Stanfield
Gentlemen Welcome – Inquire at Registration Desk.

Youth Program

Family Day – see Ladies' Program

THURSDAY, JUNE 10

CMA and Council

8.30 a.m. – 5.00 p.m.
Press Room B
Nova Scotian, Northumberland Room

11.00 a.m. – 5.00 p.m.
Press Room A
Lord Nelson, Salon No. 4

11.00 a.m. – 5.00 p.m.
C.M.A. Convention Office
Lord Nelson, Salon No. 5

1.00 p.m.
C.M.A. Board of Directors Meeting
Nova Scotian, Fundy Room

Scientific Program

Nova Scotian, Commonwealth Room

8.15 a.m. – 5.00 p.m.
Registration – Scientific Program
Nova Scotian, Convention Floor

8.30 a.m. – 1.00 p.m.
BUSINESS OF MEDICINE SESSION
Chairman: Dr. D. Gellman

1. *The Canadian Economy – Income Tax & the Physician*
   The Hon. Edgar J. Benson, Minister of Finance

Reactor Panel:
Mr. I. Barrow, Halifax
Mr. F. Covert, Halifax

2. *Medical Practise Business Management*
   Mr. P. Fraser, Toronto

3. *How should we practise – Solo or Group – Through partnership or corporation?*
   Mr. J. Paul, Vancouver

2.00 p.m. – 5.00 p.m.
OBSTETRICS & GYNAECOLOGY
Chairman: Dr. G. H. Flight

Principal Discussants:

Dr. D. J. Marchant, Boston
Dr. R. A. Kinch, Montreal
Dr. R. P. Beck, Edmonton

Subjects & Case Presentors:

1. *Rubella & Pregnancy* –
   Dr. W. R. C. Tupper, Halifax
2. *Premature Rupture of the Membranes* –
   Dr. J. Scott, St. John's
3. *Abnormal Vaginal Bleeding* –
   Dr. M. B. Kingston, Charlottetown

Miscellaneous Events

9.00 a.m. – 3.30 p.m.
Exhibits Open

9.00 a.m. – 3.30 p.m.
Horner Art Salon
Nova Scotian, Convention Floor

9.00 a.m. – 5.00 p.m.
C.P.A. Scientific Program
Lord Nelson, Imperial Ball Room

Social Program

6.30 p.m.
Lobster Soirée
Immigration Shed

Ladies' Program

9.30 a.m. – 4.00 p.m.
Registration & Hospitality
Nova Scotian, Chart Room

9.00 a.m. – 4.00 p.m.
Hospitality Suite
Nova Scotian, Chart Room

9.15 a.m.
Lunenburg Tour – departing from Hotel Nova Scotian for an open tour of Nova Scotia's scenic South Shore as far as Lunenburg with tour of National Sea Products, Luncheon at Bluenose Lodge and stops at other points of interest.
Hostess: Miss Elena Roberts, *Queen of the Sea.* (Limited Tickets available)

or

10.00 a.m. – 12.00
and
2.00 p.m. – 4.00 p.m.
Tour of Izaak Killam Memorial Hospital for Children, Sir Charles Tupper Building – where coffee will be served, then on to the Killam Library.
Buses leave Hotel Nova Scotian at *9.45 a.m.* and *1.45 p.m.*
50 guests in the morning – 100 guests in the afternnon when husbands are welcome.

11.45 a.m.
Lady Golfers' Luncheon
Ashburn Golf & Country Club

1.00 p.m.
T. Eaton Trophy Tournament
10 and 18 hole competitions

7.00 p.m.
Lobster Soirée
Immigration Shed
(Warm casual clothes are suggested for several of these activities).

Youth Program

9.30 a.m. – 4.00 p.m.
Puppet Show by the Junior League of Halifax, Handcraft and Games
Fort Massey Church Hall

Hike and Cook-out
Point Pleasant Park

(Alternate program if raining: Tour of Nova Scotia Museum)

FRIDAY, JUNE 11

9.00 a.m. – 5.00 p.m.
C.P.A. Scientific Program
Lord Nelson, Imperial Ball Room

9.00 a.m. – 5.00 p.m.
Lancet Management Limited
Board of Directors Meeting
Nova Scotian, Fundy Room

SATURDAY, JUNE 12

9.00 a.m. – 5.00 p.m.
C.P.A. Scientific Program
Lord Nelson, Imperial Ball Room

9.00 a.m. – 5.00 p.m.
Lancet Management Limited
Board of Directors Meeting
Nova Scotian, Fundy Room