THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION

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THE NOVA SCOTIA MEDICAL BULLETIN

The Mace

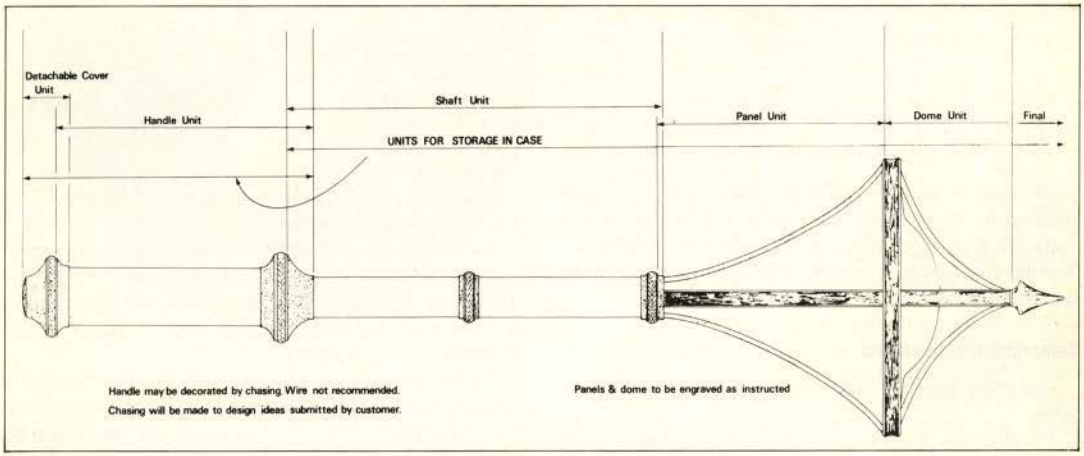


PLATE A

The desirability of having a mace for The Medical Society of Nova Scotia has been well recognized and indeed was accepted in principle by the annual meeting of 1972 and the authority for proceeding with the design was given at that time as indicated in Dr. G. W. Turner's editorial in The Nova Scotia Medical Bulletin, Dec., 1973. The design of the mace as described in this issue is the product of the Archives Committee of The Medical Soceity of Nova Scotia.

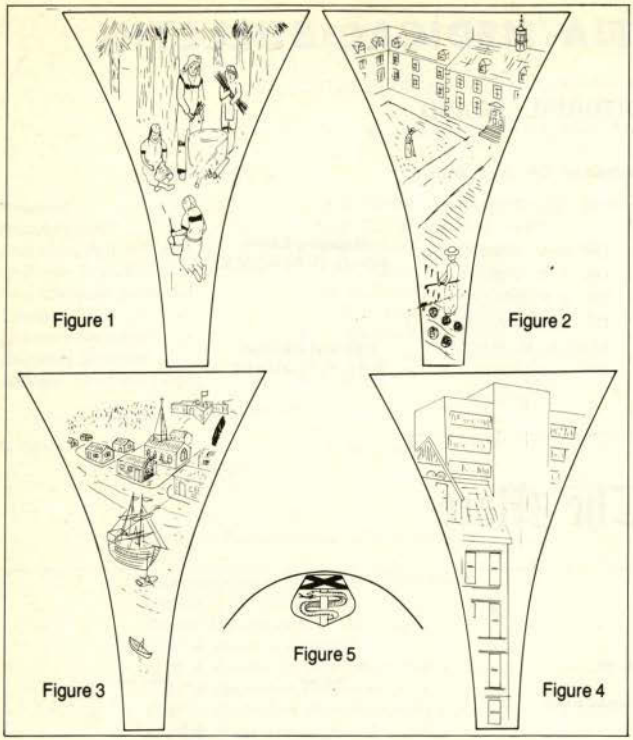
Through the years the mace has been a symbol of authority, and now a suitable symbol to reflect the dignity and importance of organized debate and discussion. Because the mace typically symbolizes the tradition of the body utilizing the mace, it was felt that the design which would become an integral part of the completed mace should embody the medical tradition of our province.

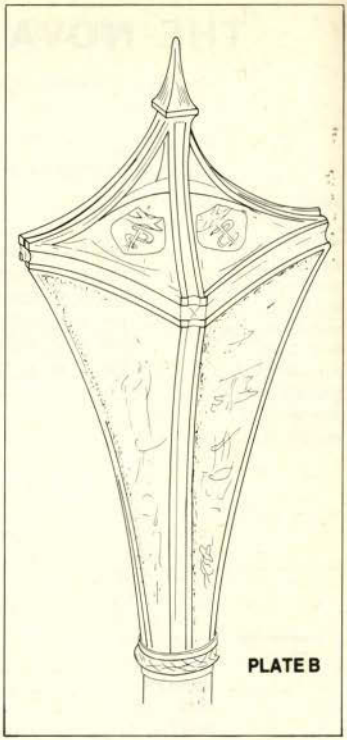
The mace historically was not a staff or pike, but a hand weapon designed primarily to be swung like a club, and therefore had to be easily held in one hand.

Concept of Design

Nova Scotia's recorded history first appears on maps drawn by the Portuguese as early as 1507. At that time the Portuguese were primarily interested in fishing grounds and they therefore were labelling capes and harbours on Cape Breton Island which would be beneficial to their fishing fleet. In as much as charts post date events as books, discoveries, and accepted patterns of behaviour do, it seems reasonable that Nova Scotia, or at least Cape Breton Island was known to the Portuguese fishermen within a few years of Columbus' discovery of America, in the last decade of the 15th Century. Therefore, the design of our mace was planned around those dating from the mid 15th Century.

A mace portraying the historical tradition of Medicine in Nova Scotia was projected to be constructed from the many woods and metals available in Nova Scotia such as Bird's eye Maple, Oak, or Pine; Silver and Gold; Agate and Coal. It was soon clear that the woods could not be carved as minutely as





silver could be engraved, and that the weight and shapes required for the finished mace made the use of multiple materials impractical from a strength and cost standpoint. Therefore, construction from Nova Scotia silver plus a facing with gold was chosen.

Description of the Mace

The entire design is shown in the accompanying illustrations.

The side view (Plate A) gives a full size picture of the entire mace. The handle is metal and hollow, with the base of the handle unscrewing to allow access to a core recess which will hold the scroll listing the presidents and major officials of the Medical Society from its inception to date. The scroll can be lengthened and thus kept up to date at all times without increasing the weight of the overall mace, or detracting from its design by the addition of plaques or other items.

The head of the mace has four concave surfaces and a dome. Each one illustrates a period in the development or history of medicine in Nova Scotia. These are shown in the "triangular" drawings and will be engraved on silver.

The first (Figure 1) is an illustration of the Micmac Indians boiling herbs to extract the liquor. This is evidence of the first therapeutics known in Nova Scotia and dates from the middle 1500's to the middle 1600's. It is the earliest recorded "medicine" in our province.

The second (Figure 2) represents the French and Acadian period in Nova Scotia and shows the hospital at Fortress Louisbourg with the garden tended by the Reverend Brothers. The hospital at Louisbourg probably reflects the culmination of French medicine in Canada embodying the nursing skills of the Brothers, plus the surgical skills of the then physicians, and a designated area where the sick could be best cared for.

The third plaque (Figure 3) represents the colonization of British Nova Scotia and shows the early town site of Halifax with the naval facility with naval medicine in the foreground, and the town site with the beginnings of British civilian medicine in the background.

The final plaque (Figure 4) represents the modern period of medicine in Nova Scotia illustrating its educational facilities, the old Forrest building in the foreground and the modern Sir Charles Tupper Medical Building in the background. These are symbolic of our present methods of practice and the teaching of medicine in Nova Scotia.

The oblique sketch (Plate B) shows the four plaques covered by a dome suspended within the framework at the top of the mace, each of the four triangular plaques being surpassed by the coat of arms of The Medical Society of Nova Scotia, reproduced on each quadrant of the dome, symbolically representing our members getting together for discussion and debate, and thus embodying all of our glorious heritage.

As can be seen by the side view (Plate A) the mace disassembles for storage and transportation. Therefore, as the official functions of the Society move about our province for adequate representation and discussion by its membership, the traditional embodyment of authority, the mace, can be easily transported with them, being a visible symbol of the Society's integrity and high purpose at all times.

□

Archives Committee,
The Medical Society of Nova Scotia.

Archives

Richard Hand,* B.A. (Dal.),
Halifax, N.S.

It was that famous local statesman of yesteryear, Joseph Howe, who said: *"A wise nation preserves its records, gathers up its muniments, decorates the tombs of its illustrious dead, repairs its great public structures and fosters national pride and love of country, by perpetual reference to the sacrifices and glories of the past."*

A present local medical body in the province of Nova Scotia seems to have heard Howe's words reverberating through the ages, and intends to practice what he preached. This is the Archives Committee of The Medical Society of Nova Scotia under the present chairmanship of Dr. Robert F. Hand.

The Archives Committee, which was initiated in 1971 under the past chairmanship of Dr. C. J. W. Beckwith, was active from the start with the exception of 1972 when things went into a temporary dormancy, but was revitalized in 1972.

But what must be the most outstanding accomplishment of the Archives Committee is the acquisition of a partitioned 1000 square foot section of the Kellogg Medical Library on the second floor of the Sir Charles Tupper Medical Building.

This area of the library, known as the Special Collections Section, contains the collected Archives and a rare book section on medicine. One book in the collection dates from 1483. The book, 'De Proprietatibus Rerum', was written by Bartolomaeus Anglicus, a priest, and published in Cologne. It is written entirely in Latin, and the translation of its preface says that it was "aimed at collecting universal knowledge."

About this book, ". . . some things haven't changed that much since that period, but of course, other matters have changed dozens of times," says Mr. A. H. MacDonald, Kellogg Librarian and member of the Archives Committee.

Among other rare books in the collection, there is one by Hippocrates dating back to 1657, and Mr. MacDonald adds, "We have recently acquired a set of books from a physician who practiced in Nova Scotia around 1830."

"Within the library, we have several special collections which include the history of medicine and an instruments collection . . . (But) our main activity at the moment is to organize the records of the Archives," states Mr. MacDonald. The Special Collections Section proves to be an invaluable space for all the old works and items as it is a climatically-controlled secure area of the library, which helps to prevent unwanted ageing of the collection.

But, in addition to the old (and new) works of medical literature to be found in the Special Collections Section, "Another component is the collection of surgical instruments from the past 150 years . . . We are currently working on a display on smallpox and its treatment from witchcraft to up-to-date techniques."

These displays appear regularly in the foyer and library of the Sir Charles Tupper Medical Building on University Avenue in Halifax. They are comprised of items taken from the collection in the Archives so that the general public may view them.

However, when it is open, the Archives are for serious public use. One of the pet-peeves of the Archives Committee is that the facilities are not being used enough by the public. In a place where they "have so much about medicine from past to present time," says Ms. Mary Burton, it does indeed seem a shame that the Archives are not being used as much as they should.

"Mainly the archival library is a consortium of historic odds and ends where people can browse. It's a shame that so few people use the facility," says Ms. Burton, Keeper of the Records at the library. Ms. Burton adds that it is possible that "many books can be taken out by regular library users as long as the books are in reasonable condition."

Dr. W. A. Murray, secretary of the Archives Committee,

*Present Address, Student, Faculty of Journalism, Ryerson College, Toronto.

concurs with Ms. Burton about feeling that not enough people are using the medical Archives. He expresses the sentiment that, "The more the public is aware of the medical history of this area, the better it is for all." However, Dr. Murray and his associates anticipate that the Archives will gain in popularity in the near future. "We're having a meeting soon to discuss having a person at the Archives full-time who will be always readily accessible."

Dr. Murray continues, "Basically, the Archives are a continuing thing. The Archives are a collection of material relative to medicine in Nova Scotia. In time we hope that this will broaden to cover material from all of the Atlantic Provinces."

"By making our collection grow, we hope to gain regional and national interest," and, Dr. Murray optimistically adds, "we hope to get material from across Canada as we naturally relate to the profession on a national scale."

Chairman of the Archives Committee, Dr. Robert F. Hand, feels that the new medical archival library "has been our principal accomplishment so far", and thinks that "the medical student employed last summer has with the help of one of the librarians properly catalogued and arranged much of the material in the Archives' collection."

Dr. Hand would like to see more medical students hired for this purpose during successive summers. Mr. MacDonald thinks this would be good because, ". . . we have plenty of work for them as long as we can obtain sufficient money to support them."

To date, the money for students has been donated by various medical bodies in the area. Dr. Hand says, "The Medical Society of Nova Scotia, the Provincial Medical Board of Nova Scotia, the Dalhousie Medical Alumni and the Dalhousie University Faculty of Medicine have all been very generous in raising funds for summer students to work on our projects."

Dr. Murray too would like to see a continuation of the use of medical students during the summer. "We hope to continue the summer program. Another thing that students did in the past was taping senior doctors in the province about their medical experience. These are permanent records and we hope that this will expand further."

As a token of thanks, Dr. Hand says, "I would like to pay particular tribute to the Dean of Medicine at Dalhousie University, Dr. Lloyd B. Macpherson, and the Chief Librarian, Mr. MacDonald, for their great enthusiasm and help in making available such excellent space for us in the medical library."

But the medical Archives would not have been as great a success as they are without the many contributions and donations that the Archives Committee has had.

"There has been a continuous flow of donations and gifts ever since the Archives' establishment," informs Dr. Murray," and all material of archival-interest are continually urged to be contributed."

Mr. MacDonald says, "We appreciate any gifts we may acquire, and we get a tremendous amount of things given to us annually." He feels that people should not be afraid to donate items, because the Special Collections Section is always kept locked when there is nobody in attendance. "For something substantial," he continues, "we will pay the shipping costs." Also, "The University has made a committment in the provision of space, and hence the Archives will be here a long time. The Archives have become an institution."

"The objective," Dr. Murray magnifies, "is to continually improve and add to the collection and have it all catalogued to keep the profession and the public aware of its historical, professional and social value as an institution in our society."

Regarding the future, Dr. Hand says he does not think that there will be any particular plans "until the present project is quite complete. In addition, there is always the matter of continuing to collect important material and I would like to appeal to everyone to contribute items of interest particularly as we can now assure them of safe custody."

Mr. MacDonald urges that, "We're very interested in any correspondence and other contributions pertaining to the development of medicine in this region."

Dr. Murray finalizes that, "We have the help, and increasing activity is important to make it a significant factor of an increasing awareness of our predecessors, and informing future generations how far we have really come." □

Outline of the Reproductive Care Program for Nova Scotia

PART I: AIMS AND OBJECTIVES — WHAT THE PROGRAM OFFERS — WHAT NEEDS TO BE DONE

D. W. Cudmore,* M.D., F.R.C.S.(C)., F.A.C.O.G., and
K. E. Scott,** B.Sc., M.D.,

Halifax, N.S.

AIMS AND OBJECTIVES OF THE PROGRAM

The Reproductive Care program is sponsored by The Nova Scotia Medical Society, and is an extension of previous studies carried out by its Committee on Maternal and Perinatal Health. Its aims are to promote the development of the best quality of reproductive care possible, to see that women and their babies have access to advances in care as soon as they become available, to assure that all women in the Province have access to the same high standard of care, and that this organization of care should add to rather than detract from the quality of community life. Each newborn infant should have the best possible chance of survival, without neurological sequelae due to events surrounding the perinatal period, and having the mother, father, and the other children in the family already accepting him.

Only a few mothers and their babies need to move to facilities outside their community to obtain maximum care. When this proves necessary all effort should be made to see that the family relationships are given an important priority.

These aims and objectives will not be accomplished without the participation of physicians, nurses, hospital personnel, voluntary organizations, the public health nursing service, and educational institutions. The broad objectives are aimed at the improvement in the whole quality of life surrounding women during their reproductive period. The results will be a major reduction in prematurity & maternal and perinatal mortality.

WHAT THE PROGRAM OFFERS

(A) Obstetrical Hotline

This is a Zenith number 425-6245, and may be called toll-free at any time (24 hours a day, 7 days a week) for help or advice in the management of a high risk patient during pregnancy, labor, or delivery.

(B) Telepede Telephone Service

This number is Zenith 07840, and can be called toll-free on the same basis for help or advice concerning the management of neonatal problems.

(C) Perinatal Mortality Reviews

Each hospital in the Province and each branch medical society has received a summary of its perinatal mortality statistics for the period 1965-1972, with comparisons with other regions, hospitals, etc. and some interpretation of their meaning.

Hospital perinatal mortality surveys based on detailed chart reviews, with presentation of results and recommendations, will also be carried out on request.

Continuing perinatal mortality reviews will be carried out by the yearly collection of statistics, completion of perinatal mortality forms, and yearly reports to the hospital staff. Neonatal morbidity surveys could also be done by medical record room staff, using a common discharge summary.

(D) Visiting Nurse

A nurse will visit any hospital by request, to survey the nurseries and case rooms for equipment, facilities and procedures, and will be prepared to submit a report with recommendations to the nursing service. She will also work with the nurses in the hospital as desired.

(E) Hospital Assessment

Each hospital on request will have an assessment of equipment, policies, facilities, and an examination of the possible directions for its future role in reproductive care.

(F) Forms

Common labor, delivery, nursing note, newborn, and discharge forms will be available to all hospitals. Neonatal referral forms are also available.

Common prenatal and risk identification forms will be supplied to the physician.

(G) Manuals

Manuals will be supplied to each hospital, an obstetrical and a neonatal procedure manual, a nursery procedure manual, and a summary of procedures for transport of ill patients.

(H) Lists

Lists will be supplied for case rooms outlining categories of high risk pregnancy, and high risk neonates including hypoglycemia.

(I) Family Centered Maternity Care

An outline of the Family Centered Maternity Program is available with help and advice in initiating such a program, from the Project Coordinator, Mrs. Doris Davidson.

*Assistant Professor, Department of Obstetrics and Gynaecology, Dalhousie University.

**Associate-Professor of Pediatrics, Assistant Professor, Obstetrics and Gynaecology, Dalhousie University.

(J) **Education — General**

The long-term goals of improvements in reproductive care over the next 10 to 20 years will require major emphasis on education of the woman in the reproductive period, and the personnel attending her.

(1) Education in health care during pregnancy. Girls require education in the role of good health and its effect on their offspring during pregnancy. This will need to be done through some revamping of health courses in the schools.

(2) Education of young women in the community who are now beyond the school age.

(3) Education of women who are presently pregnant to seek prenatal care, to learn the importance of good diet, adequate rest, and early detection of problems, so that the pregnancy outcome may more likely be a happy one. These last two goals can be achieved by using communications media such as television and radio, and continuing to expand the role of the public health nurse in the community.

(4) Education of physicians.

Past approaches to continuing education have often emphasized the didactic approach or the review of cases in which the outcome has already been decided. A change in emphasis to give the physician the opportunity to discuss the management of a patient who is now presenting with problems will probably increase his involvement in the educational process. As well, clinical traineeships are available, which physicians should be encouraged to utilize more frequently.

(K) **Education — Nurses**

Ample opportunities now exist for nurse education; the Obstetrical Course and the Neonatal Intensive Care Course are held several times a year, and are available to nurses in the Province.

Nurses are encouraged to take one to two week periods of training in a central unit if they are unable to attend the three months' obstetrical or neonatal courses. Nurses who have taken the three months' course should consider taking a weeks' refresher at least once every year.

An association of nurses in obstetrics and neonatal care is in existence, information is available, and all nurses involved in this type of care may become members. This offers communication and teaching seminars with others working in the same field. A newsletter, edited by the Visiting Nurse (Mrs. Davidson) is circulated monthly as a means of keeping obstetrical and neonatal nurses in contact with most recent developments.

(L) **Education — Nurse Exchange Program**

The Nurse Exchange Program, where a nurse would spend a short period in a central unit while a nurse from the central unit would spend the same time in the community hospital, is now available.

(M) **Project Coordinator**

Mrs. Doris Davidson is the coordinator of the project as well as the Visiting Nurse. She may be contacted at any time concerning any aspect of the Program.

(N) **Other Personnel**

Questions concerning medical or perinatal review aspects of the Program may also be referred to Dr. Cudmore or Dr. Scott. Dr. Rees is particularly expert in neonatal transport; Dr. Michael Hebb is coordinator of the Nova Scotia Fetal Risk Project.

WHAT NEEDS TO BE DONE

(A) **Overall Plan for Intrapartum and Neonatal Facilities in the Province**

In general, obstetrical care should be concentrated in hospitals with a geographic and community reason for existence, and care should be upgraded in these hospitals.

Cape Breton should be considered a unified perinatal health area, with a central referral perinatal unit for high risk obstetrical and neonatal care, suitably staffed and equipped, for all predictable high risk mothers in Cape Breton, and all unpredictable high risk patients within the geographic area of Sydney. Until L/S ratio, oestriols, ultrasound, and fetal monitoring are available in the area, the ultra-high-risk should continue to be referred to the Provincial Reproductive Care Center.

The Halifax-Dartmouth metropolitan area should have one central perinatal intensive care unit for all community high risk pregnancies, and for the predictable very high risk pregnancies for the mainland. The central referral neonatal intensive care units (Sydney, and Halifax) for the very ill infants from the community and regional hospitals should be used to their full capacity. The metropolitan area now has fertility and family planning clinics, but should have in addition a wide range of specialty clinics for the referral of difficult obstetrical problems.

Mainland Nova Scotia should have geographically located medium risk regional perinatal units, using the central referral perinatal and neonatal intensive care units for the very high risk pregnancies and neonates.

(B) **The University**

The awesome time gap in the diffusion of information implied by marked differences in regional mortality rates requires investigation. Are our methods of continuing medical education sufficient to cope with the rapid increase in knowledge and techniques? Should we be using close-circuit television or conference telephones to carry on obstetrical-neonatal high risk rounds, where physicians could present their current problem patients for discussion and advice?

There should be a means for the specialist in the regional areas to have appointments in the University Departments of Obstetrics and Pediatrics. These physicians would give valuable feedback on the community needs, and would have another mechanism of keeping up to date on recent advances.

(C) **The Physician**

He should assess, examine, and define his own future role in

reproductive care. Does he have many or few obstetrical patients? Should he build up his obstetrical practice or perhaps encourage someone else to take it over? Should he do only the normals or does he have knowledge and experience to apply the recent advances in modern perinatal care to his high risk patients? Does he have the time to do good prenatal care? Is there a place for an organized prenatal care clinic in his area? Should he develop further expertise in obstetrical-neonatal care through clinical traineeships etc., or should he be prepared to give up some of his prerogatives to a person with extra training and more recent knowledge?

The physician who decides to continue to practice in this area of medicine should be prepared to alter his practice in order to bring the most recent improvements in care to his patients.

He should:

— promote the concept of strategically located obstetrical-neonatal units in selected areas to deal with the mild to moderate risk and the unpredictable high risk pregnancy.

— grade all pregnancies for the degree of risk at the first and each subsequent office visit.

— define abnormal conditions early enough that the process is not irreversible or already damaging and the outcome can be a normal survivor.

— delineate the personnel and facilities necessary for the stages of the high risk pregnancy, select and seek out the facilities appropriate to the risk.

— having defined the type of care necessary, and having decided where that care can best be provided, make certain that the patient obtains the care (it is the patient who has the problem and the doctors and hospitals should assess the needs for care and persuade the patient to obtain the care).

(D) The Hospital

Each hospital staff should evaluate and define its future role in reproductive care. Are there geographical reasons for continuing to do obstetrical care? If there is another hospital close by they should cooperate to combine obstetrics in the one facility.

If there are valid reasons to continue to do obstetrical care, then perhaps the whole program of reproductive care should be re-examined. What is the role of a community hospital in this field? Is it just a place for a woman to come in in the late stages of labor, deliver the baby, rest a few days, and go home, or is there another role? Should the community hospital not be prepared to take on a much more expanded role in reproductive care? Should it not be a health care resource center for information on family life and health education for pregnancy in the schools, a center for family planning, a community center for promotion of programs to reduce prematurity and fetal malnutrition? Should it not be screening the pregnant woman for early diagnosis of twins; should it be prepared to set up prenatal classes and prenatal clinics where there is a need? What proportion of the pregnant women in the community obtain adequate prenatal care?

The role of a community hospital during and after delivery is also important. A woman often wants the support of her husband during delivery. She would often like to hold the baby for a short time after the birth. This is an important opportunity for a hospital to contribute to the improvement of family life. Should the father and children not be able to be in the room with the new baby? Should the mother spend her time watching television and reading magazines while the nurses care for the baby? Is this an important time for the new mother to learn to care for the baby, with expert teaching by skilled nurses, and perhaps try breast feeding, to promote the bonding relationship? Perhaps, then, there is an important new role for the community hospital as a center for expansion of this facet of medical and preventive care.

(E) Community and Voluntary Agencies

A woman who must have prolonged bedrest at home should have some home care resources to help with housework, care and supervision of children. For those families where the mother must leave for a considerable time because of high risk antepartum supervision in hospital, homemaker programs could be available so that the family is not disrupted during this period. Accommodation for the family should be available close by the referral hospital for occasional visits. The high risk mother should also be able to have a child stay with her overnight on occasion. When a premature must be left in hospital the mother should be encouraged to stay in hospital overnight or weekends when possible, to care for the baby.

(F) Public Health Agencies

There is an increasing interest in and need for prenatal classes to supply teaching to the pregnant woman and her family concerning health care during pregnancy, including exercises and preparation for childbirth. Organized prenatal clinics may also be necessary in some areas. At the same time, selected women with high risk pregnancies could spend a large part of their time at home, and would benefit from dietary advice and supervision and perhaps planned dietary supplements.

These agencies could also take on the burden of education programs, of media education of the public in optimal reproductive care, of the promotion through the schools of health education for pregnancy, family life education classes, fertility and family planning. Programs for the reduction of prematurity, reduction of fetal malnutrition through good maternal nutrition, and screening for diagnosis of twins could also be initiated. □

Due to an unfortunate oversight, the encouragement and strong support for a Patients' Bill of Rights on the part of the Provincial Medical Board was not mentioned in the last issue of the Bulletin. We apologize for this, the more so because the Board has been a consistent champion of excellence and humane service in the field of medicine and a consistent proponent of dignity, decency and confidentiality in relations between the entire medical care delivery system and the patient.

Ed.

INFORMATION FOR PHYSICIANS IN NOVA SCOTIA REGARDING THERAPEUTIC ABORTION

A Statement by the Department of Obstetrics and Gynaecology
Dalhousie University

There have been a number of tragic delays in making arrangements for therapeutic abortions. Some of these have resulted in abortion not being possible in situations where the attending physicians and consultants felt the abortion was indicated. Also it should be pointed out that a number of abortions have had to be done in hospital by the saline method because of delays in administration, mostly delays caused by medical people.

We think everybody would agree that therapeutic abortion is a traumatic experience and there is no question that the later the abortion has to be done, the more difficult it is in every way for the female person involved.

The Department of Obstetrics and Gynaecology at Dalhousie has now had several years experience dealing with therapeutic abortion cases and we make the following recommendations to the physicians in Nova Scotia.

1. If a patient presents to a physician to discuss or request therapeutic abortion and a physician has a conscientious objection to therapeutic termination of pregnancy under any circumstance, it is the physician's responsibility to indicate immediately to the patient that he will not be associated with her case at that time. He ought to also immediately direct her to another physician or state that she is at liberty to see another physician as soon as possible.

2. If the physician does accept the case and after considering all the circumstances decides that the patient should not have a therapeutic termination, then it is his responsibility to indicate this to the patient at once and also to advise her that she is at liberty to seek the opinion of another physician. He may actually assist her by making a referral for this purpose.

3. If the physician decides that there are indications for therapeutic termination of the pregnancy, he should send a letter to the Therapeutic Abortion Committee of his REGIONAL HOSPITAL outlining the circumstances of the case and giving very clear reasons for recommending the termination including a suitable diagnosis. A clear, positive recommendation is essential for the Committee. Vagueness and incompleteness in the physician's letter may well lead to delay or rejection on the part of the Committee with consequent suffering and hardship on the part of the patient. It is the physician's responsibility to insure that these communications reach the Committee promptly. There is really no excuse for delay of more than a day or two.

4. Most hospital Therapeutic Abortion Committees require the additional opinion of a consultant. Normally the consultant would be a specialist in the field wherein the indication for therapeutic termination lies. The physician should be familiar with the regional hospital regulations in this regard and ensure that the regulations concerning consultation are met correctly and promptly. This includes making arrangements for the consultant to see the patient at the earliest possible date and urging the consultant to send the report to the Committee at once.

5. Some hospital Therapeutic Abortion Committees will accept the opinion of the patient's physician without consultation provided the physician makes a personal presentation to the Committee. The physician should be aware of the policies of the Committee in the regional hospital.

6. The Therapeutic Abortion Committee having considered the case will indicate its decision to the referring physician at once, usually by telephone but sometimes by letter; it is then the physician's responsibility to inform the patient of the decision.

7. If the decision is in favor of the therapeutic termination, the physician should refer the patient at once to a gynaecologist or family physician or surgeon who is qualified to carry out therapeutic terminations in the hospital concerned. Any delay at this stage will only cause the patient additional hardship and increase the risk and difficulty of the procedure.

8. It will be the duty of the gynaecologist or surgeon or family physician who carries out the procedure to ensure that the quickest and safest possible procedure is used bearing in mind the hospital's policies and also to ensure that an Rh negative patient is covered with passive immunization using anti-D-Gammaglobulin. It is also the duty of the person performing the procedure to ensure that the patient understands the procedure itself and its implications and refers the patient back for recheck and follow up examination to the primary referring physician.

9. The primary referring physician who sees the patient for a check up and follow up should determine whether or not additional counselling or therapy will be required. Where indicated the physician should also ensure that the patient is fully cognizant of suitable contraceptive measures.

10. It may very well be appropriate to use the assistance of allied health personnel in the management of these patients. A number of professionals of various kinds are available in the province and some are highly trained and skilled in assisting in the management of cases of this kind. The physician should be aware that this type of professional assistance is available and use it where it will be helpful.

11. If the above procedures are followed carefully, there ought to be practically no cases where therapeutic termination of pregnancy is carried out beyond about 10 weeks of pregnancy.

12. A negative pregnancy test, where a patient or physician suspects pregnancy, should be REPEATED in two weeks. □

Maintaining Standards of Anaesthetic Care in Nova Scotia

John H. Feindel,* MD., C.M., F.R.C.P.(C),

Halifax, N.S.

Canada shares a unique position with few countries in the world, in that anaesthetic care is not yet delegated to a nurse practitioner or anaesthetic technician. To allow unsupervised technicians to administer anaesthesia would be a retrograde step and must be avoided. The present quality of anaesthetic care must be maintained. For some time to come, it is quite apparent that we will be dependant on general practitioner anaesthetists to meet the ever increasing demands for anaesthetic services and steps must be taken to ensure these practitioners are kept informed of improvements and innovations in the specialty.

If the present level of anaesthetic care is to be improved upon and the demands for the expansion of anaesthetic services are to be met, we must make provision for the future. The future manpower requirements in anaesthesia must be filled by qualified and properly trained medical practitioners. The production of specialists in anaesthesia has decreased in recent years. The number of anaesthetists who successfully pass the certification examinations has been decreasing each year. There is also a serious shortage of qualified applicants for the anaesthesia training programmes at all university centers throughout Canada and this is particularly true in Nova Scotia

In Nova Scotia, it is still possible and quite common for any medical practitioner, regardless of his experience and training, to perform anaesthetic procedures in hospitals. These medical practitioners must be given an opportunity to improve their knowledge of all subjects pertaining to the practice of anaesthesia. The teaching hospitals of Dalhousie University have continually expressed their willingness to instruct practitioners in the safe use of modern anaesthetic techniques.

Many factors have tended to cause an increase in the demand for anaesthetic services in Nova Scotia. During the past ten years, at the major teaching hospitals in Halifax, the number of anaesthetic administrations has increased at a rate of 12-15% per year. In other words, the anaesthetic workload has increased by well over 125%. In that period, there has not been a corresponding increase in the number of anaesthetists. This has necessitated a substantial increase in productivity on the part of the individual anaesthetist.

The first and most important factor responsible for increasing the need for anaesthetic services has been the introduction of new surgical procedures. Many surgical procedures which are now performed routinely were infrequent or unknown ten years ago. The following are examples of such procedures.

Total replacement of the hip joint.
Hip arthroplasties.
Nasal septoplasties.
Sterilization procedures i.e. tubal ligation, vasectomy.
Open heart procedures.
Organ transplants.
Procedures for retinal detachment.
New surgical procedures for the treatment of cancer.
Cardioversion.

The second factor which tends to increase the demand for anaesthetic services is the building of new hospitals. Each new operating room which is added to the existing health care facilities, requires an additional anaesthetist to permit its efficient use.

The third factor contributing to the demand for anaesthetic services has been the introduction of Medicare which has made a wide variety of elective surgical treatments available completely free of charge to the people of Nova Scotia.

It is quite likely that the need for anaesthetic services will continue to rise each year. What steps can be taken in anticipation of the rising need for more anaesthetists in the province and at the same time ensure a high standard of anaesthetic care?

Firstly, medical students and interns should be encouraged to give serious consideration to making a career of the specialty of anaesthesia. They are certainly needed to meet the manpower requirement of the specialty. Most medical students are idealistic and have been motivated to take training in medicine because they want to help treat and cure patients who are seriously ill, as well as relieve their pain and suffering. They want also to be able to put into practice the principles learned in such basic sciences as physiology, biochemistry and pharmacology. The specialty of anaesthesia is ideal for students who are so motivated they must be attracted to the specialty. To make anaesthesia more attractive we must improve the working conditions of the individual anaesthetist. The clinical workload of each anaesthetist must be reduced to more reasonable levels to permit more time for case analysis, clinical investigation, supplementary reading and attendance at refresher courses. In order to attract good candidates into the residency programme, the annual incomes of anaesthetists will have to be at a level which is higher than other medical specialties.

The second measure to be taken in anticipation of the need for more anaesthetic services, is to provide a more intensive programme of continuing post graduate education for general practitioners performing anaesthesia. The division of continuing educaton at Dalhousie University has been providing clini-

*Head, Department of Anaesthesia, Halifax Infirmary. Associate Professor, Department of Anaesthesia, Dalhousie University.

cal traineeships and short courses in anaesthesia, but these have been rather poorly attended. There is a need for government support in the form of financial incentives to family practioners to enable them to take additional training in anaesthesia. There should be a greater utilization of the "on site" training of general practitioners, in their own working environment, by specialists in anaesthesia from Dalhousie University.

Thirdly, it is imperative that all hospitals have well organized departments of anaesthesia, with each one supervised by medical practitioners who have been appointed as directors. Ideally, these department heads should be certified specialists in anaesthesia, but as a minimum requirement, they should have had the best possible training and experience. More rigid qualifications are necessary before a practitioner can be allowed to administer anaesthetics in hospitals.

The department head has the final responsibility for the quality of anaesthetic care.

As an initial step in preserving and promoting quality care, it should be stipulated that anyone performing anaesthetic procedures should have a minimum of six months training at a university training centre which is recognized by the Royal College of Physicians and Surgeons of Canada.

In the future, we must continue to rely upon the general practitioner to assist in providing anaesthetic care. The need for anaesthetic services is likely to continue to rise each year. If this demand is to be met and the quality of anaesthetic service is to be preserved, continued cooperation will be necessary between the General Practitioner Anaesthestist, the Specialist Anaesthetist, The Medical Society of Nova Scotia, the Department of Anaesthesia at Dalhousie University and the Medical Services Insurance Commission. □

ANAESTHESIOLOGY

Hand maiden of the charnel priest,
Pure as a vestal virgin,
He spreads the sacrificial feast
Before the Lord High Surgeon.
He glowers when the Master smiles,
Guffaws when he should smirk,
Tries all his black and occult wiles
To bug the surgeon's work.
The lungs expand a rubber bag
With breath from iron bottles,
Your spirit like a broom stuck hag
Soars high on witches wattles.
He leads you on to Lethe's shore,
Yet stays you at the brink,
Nor in that stream of Nevermore
Will let your burdens sink.
He will not give that gentle shove
To loose your earthly hold,
Because his heart is pure as love,
Unstained by greed or gold.
He brings you, somehow, back to life,
Unhappy and unsung,
Into the midst of that hard strife
From which your illness sprung.
The boasts of modern surgery,
He tells in modest flood,
Rest on his holy liturgy
Of pentothal and blood.
No fancy Asiatic nails
No prods of split bamboo
Can calm the surgeon when he rails
And bring you safely through.

J. W. Reid

Please Note

The article "Nova Scotia Medical Services Insurance Physician Profiles" appears in the centre of this issue in order that it may easily be removed for ready reference. Also included in this issue is a tip-in Anti-Smoking poster which may be easily removed and used as a poster.

THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA

RESOLUTION AND STATEMENT PERTAINING TO ITINERANT SURGERY

"WHEREAS the Council of the Royal College believes that the operative procedure is only one part of total surgical care which includes making or confirming the diagnosis, preoperative preparation, the operation and post-operative care, and

WHEREAS, this Council considers that itinerant surgery does not conform to these principles,

THEREFORE, BE IT RESOLVED that this Council condemns itinerant surgery as being detrimental to the best interests of the patient.

Rare exceptions to this policy are certain cases of unusual emergency or where movement of the patient to another hospital would jeopardize his recovery.

JANUARY, 1966, reconfirmed 1974.

An Individual View of Acupuncture in China

Ian E. Purkis,* M.B.B.S., F.F.A.R.C.S., F.R.C.P.(C),

Halifax, N.S.

The recent rash of publications and articles on the 5,000 year old Chinese art of acupuncture has led to an immense public curiosity, and for those who suffer from chronic or incurable disease, acupuncture has offered a last hope. Physicians are increasingly being subjected to pressure from patients and relatives, for advice as to where acupuncture can be obtained, and for information on the cost and effectiveness of the treatment.

Most physicians cannot answer these questions, because until recently, acupuncture was regarded as being in the realm of quackery, achieving its effects through suggestion, and certainly, based on a theory of disease that was quite irreconcilable with present physiological and anatomical knowledge.

As an anaesthetist interested in pain problems, I saw many patients who had been fully investigated and treated, and who still had pain. I began to use acupuncture in these patients with encouraging but variable results. When the opportunity came to study acupuncture in China, I applied for and was accepted as a member of the delegation of nine anaesthetists and one dentist who visited China from April 5th to May 17th., 1974.

Our visit was an outgrowth of the exchange arranged by Prime Minister Trudeau during his visit to China in 1973, and the purpose of our visit was to study the use of acupuncture in the relief of pain for surgery (acupuncture analgesia) or in painful conditions (acupuncture therapy).

During the six weeks as guests of the Peoples Republic of China, we were most courteously welcomed by medical colleagues in all the hospitals we visited, and had many detailed discussions concerning the current status and usage of acupuncture. Every effort was made to ensure that we were able to see almost everything we asked to be shown, and the officials of the Ministry of Health, its Foreign Bureau, and the staffs of the various Provincial and Municipal Health Bureau looked after us royally and treated us with great solicitude. Like all guests, we could not do exactly as we pleased, and had to fit in to the plans of our hosts, so it was not possible for any of us to stay and work at any one hospital for one or two weeks at a time. Our experience, therefore, was largely one of seeing patients on one occasion only with no opportunity to watch preoperative work-up, or postoperative care, and no opportunity to see improvement following therapy for the many disease states treated.

A full report of the experiences of the delegation and our joint conclusions will be published elsewhere. For this article, I have been asked to give my impressions of acupuncture in China, and I emphasize that I am presenting a personal viewpoint of observations of work carried out by Chinese Medical Staffs of the various hospitals visited in the Peoples Republic of China.

I participated in visits to 17 hospitals where surgery under acupuncture was observed, six hospitals where acupuncture therapy was seen, and one hospital where both surgery and therapy were carried out. In addition a street clinic, neighbourhood clinic, commune brigade health clinic and a commune hospital were seen, a veterinary institute, a neurophysiological institute, and both traditional and "Western" medical colleges were visited. Our itinerary took us to Peking, Shia Sha Jang, Nanking, Shanghai, Hangchow and Canton. I saw over 100 operative procedures, ranging from dental extractions to craniotomies, lobectomies, commissurotomies and even an open-heart procedure performed under acupuncture.

Therapeutic acupuncture was seen for a variety of disease states, including neurological conditions (e.g. hemiplegia, paraplegia, Bell's palsy, tic doloreux, poliomyelitis), cardiovascular conditions (e.g. angina, hypertension), pain syndromes, (e.g. lumbago, sciatica, osteoarthritis of lumbar and cervical spine), digestive disorders (e.g. ulcer, cholecystitis) and what are classed as neurasthenic diseases (e.g. migraine, headache, insomnia, dyspepsia). It is worthwhile stating that multiples sclerosis is a rare disease in China, and our Chinese medical colleagues felt that acupuncture did not influence the course of the disease, but might produce some improvement in function. The best results were obtained in the shortest time with acute, rather than chronic pain problems, and in neurasthenic disorders. Minimal and unpredictable results, even when acupuncture had been used for months or years, were reported in chronic pain syndromes, and paraplegia, and the pain of malignant disease was only briefly helped by acupuncture.

Since records are rarely kept in therapy clinics, and are extremely brief and uninformative when kept, and since controlled trials are regarded as unethical, there is no statistical proof of the efficacy of acupuncture in these varied conditions, though the majority of patients and Chinese traditional doctors are convinced of its effectiveness. One hospital presented statistics on 252 patients with peptic ulcer, treated with bed rest, acupuncture at varying sites according to symptoms, and herbal medicines in various combinations, correlated with pre- and post-treatment radiological examination of the ulcer. However, there were no control groups, and no evaluation of the contribution of bed rest or herbal medicines separate from the effects of acupuncture. I would conclude that Chinese medicine is becoming aware of the need to maintain accurate records and to produce statistics to validate their claims concerning the effectiveness of acupuncture, but that the design of their protocols has not as yet reached an acceptable level for Western medical standards.

*Professor, Department of Anaesthesia, Dalhousie University.

The stimulus for this drive for assessment has come from the integration of Chinese traditional medicine and Western-style trained physicians, brought about by directives from Mao Tse Tung that "Chinese medicine and pharmacology are a great treasure house of knowledge and efforts must be made to raise them to the highest level". While the integration is incomplete as yet, and constitutes an uneasy marriage between two formerly competing and often opposed philosophies of medicine, there is no doubt that the political directive to combine is leading to a widespread reappraisal of the effects of Chinese traditional medical practices and the pharmacology of many herbal remedies.

ACUPUNCTURE ANALGESIA FOR SURGERY

The early reports on the effectiveness of acupuncture analgesia for surgery were the main stimulus of medical interest in acupuncture, since control of the severe pain of surgery is an acute test which must either succeed, wholly or partially, or fail, under the eye of the observer, and cannot be faked or staged. Nevertheless, what is seen and subsequently reported, depends on the bias and expert knowledge of the observer, the selection of patients, and the type of procedure performed. While some observers reported enthusiastically seeing patients who smiled, talked, ate and drank during the course of major procedures, without any evidence of pain, others have emphasized the premedicant drugs used, the intravenous narcotics given, and the supplementation with local anaesthetic agents to improve operating conditions and make the operation possible. Many observers have made the assumption that all drugs are bad for the patient and increase the risk, whereas acupuncture carries no risk. Both these assumptions are capable of being wrong, depending on the circumstances, and the apparently conflicting views of many observers can be reconciled by recognizing the wide variation in response between individual patients.

Our delegation not only saw more surgery under acupuncture analgesia, and had more opportunities for discussion and questioning than previous delegations, but we were subjected to acupuncture testing as a group and individually on several occasions. I was given acupuncture on five occasions to produce analgesia at various possible operative sites and on one occasion the analgesia produced was measured objectively by a dolorimeter. On the other four occasions, there was subjective measurement of analgesia to pinprick, and by these standards, imperfect though they were, a partial blunting of pain sensations was evident. As a result of these observations, I can say that the induction of acupuncture analgesia is never painless, and sometimes extremely uncomfortable and unpleasant, though it is a degree of discomfort which can be tolerated by most people. From my observations of patients undergoing operation, I believe that most patients felt some pain from surgery, ranging from light to severe, in addition to the discomfort of induction of acupuncture analgesia, but that these discomforts were tolerated in all but one instance by the patients concerned.

One can therefore conclude that acupuncture analgesia was an entirely possible and practicable technique for the majority of the operations seen, in this selected group of patients: two major questions that inevitably follow are, first, what is the basis of selection, and secondly, what is the motivation that brings patients to tolerate this degree of discomfort.

THE BASIS OF SELECTION

Our Chinese medical colleagues emphasized that not everyone was a suitable candidate for operation under acupuncture analgesia. The patient must be cooperative, and not very nervous, and these criteria exclude children between the ages of two and 12, the senile and mentally incompetent, and the very apprehensive patient. The site of operation influences the choice of acupuncture, since there is insufficient relaxation for large bowel surgery, and analgesia is often poor in the extremities. On the other hand, analgesia is most effective in the head and neck, and in intra-abdominal procedures requiring little relaxation, such as caesarean section and postpartum tubal ligation, and almost all patients for procedures in these areas are offered acupuncture analgesia. The duration of operation influences the choice for acupuncture, since even the most cooperative patient may become restless and uncomfortable after more than three hours on the operating table. The view of the surgeons has little influence on patient selection, since the surgeons are ideologically committed to operating on patients under acupuncture analgesia, to extending the types of operations which can be performed with this technique, and to modifying their surgical technique and improving their skills and gentleness so that the operation can be accomplished quickly and with minimum pain. It was repeatedly emphasized that the patient had the final choice as to whether acupuncture or drug anaesthesia would be used.

THE MOTIVATION FOR ACUPUNCTURE ANALGESIA

Acupuncture is a Chinese art, and the discovery of its analgesic properties in surgery is a product of post-liberation China, given special impetus by the Great Cultural Revolution of 1965-67. There is great pride in this discovery and a commitment to continually evaluate and improve the technique, on the part of all medical workers. Patients come from a society in which acupuncture is in common use for all types of disease, and accept its effectiveness. There is a conscientious belief by medical workers and patients that acupuncture is better and safer than drug anaesthesia, that there are fewer complications, that it is not contraindicated in any disease state, and that no allergic reactions can occur. It is asserted that acupuncture has a regulatory effect on the autonomic nervous system, so that fluctuations in blood pressure are less profound and of shorter duration under acupuncture. The number of surgical procedures in the hospitals I visited was about 10-15% of the number in a comparable sized Canadian hospital, so that there is no pressure to use faster, less time consuming methods. Lastly, its use is an essential component of bringing health care to an enormous rural population, in a country where medical supplies may be less than adequate in quantity, variety and distribution.

The closest analogy which comes to mind is that of Natural Childbirth, where there is a commitment to a particular method in the belief that it is the best. This commitment brings pres-

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Nova Scotia Medical Services Insurance Physician Profiles

A. W. Titus,* B.Sc., M.D., C.M.,
F. G. W. MacHattie,** C.D., M.D., D.P.H., D.H.A.,
and J. H. Hartlen,*** B.Comm., Dipl. P.A.,

Halifax, N.S.

SUMMARY

A new Nova Scotia Medical Services Insurance Physician Profile has been developed. This Profile is based on payments made to physicians for services rendered in each calendar year starting with 1973.

This paper summarizes a presentation that was given to the Executive of The Medical Society of Nova Scotia on September 7th, 1973. We hope it will serve to introduce the new profile to the physicians of Nova Scotia and help them in the interpretation of their own profile.

A profile can be defined as an outline in the form of a graph, diagram, writing etc. presenting or summarizing data relevant to a particular person or thing.

A Physician's Profile is a statistical outline of the services rendered by that physician, the patients seen, and the monies paid by Nova Scotia Medical Services Insurance in the preceding calendar year.

Physician Profiles are not new. They were first developed by Ontario's Physicians Services Incorporated and were adapted by, and improved on by the Saskatchewan Insurance Plan and later by British Columbia.

Maritime Medical Care began profile studies in Nova Scotia about ten or twelve years ago. They were similar to those of other Canadian Medical Insurance Plans. However, with the advent of universal Medical Services Insurance it was agreed, with the Government and The Medical Society of Nova Scotia, that this earlier data would not be made available. As a result the collection of MSI profile data began all over again in 1969.

Medical Services Insurance Physician Profiles have been produced every year since that time for review by the Medical Review Committee. At first these were manually produced and the first computer produced profiles became available on March 31st, 1972. To date, apart from being a catalogue of the services physicians provide to their patients, and the monies earned, it has been of little value to a physician in allowing him to compare the pattern of his practice with his peers.

The Medical Review Committee of Maritime Medical Care is charged with the responsibility of examining physicians' patterns of practice and they had the same difficulty as the single physician in interpreting profiles multiplied many times. The Committee found extreme difficulty when they attempted to compare a physician with his peers without examining a voluminous quantity of paper.

This inability of the Medical Review Committee to readily compare one physician with his peers seriously hampered their work.

Consequently, in 1972, the Physician Data Management Committee was formed within Maritime Medical Care, to work under the direction of the Medical Review Committee. Its first task was to develop a new profile whose calculations would be computer programmed. It is this profile that will be discussed.

This new profile is more informative to the Medical Review Committee and, we hope, from the physician's standpoint, as it displays all the services provided by that physician during the previous calendar year. It will allow him, and the Medical Review Committee, by the use of indices to compare his performance with his peers while still not identifying his peers as individuals. This, in our opinion, overcomes the greatest weakness of the earlier profiles making them a more accurate peer review yardstick as well as an educational tool to physicians.

Before discussing the profile and its interpretation, it is necessary to provide some clarification of the terms used:

A. Peer Group — is the clustering of physicians in suitable groups in order to make comparisons by the use of indices meaningful. Doctors in the same specialty, doing work of a similar nature with similar facilities available, or working together in a similar locale, are grouped together. For example, General Practitioners are grouped according to the community size in which they practice. Surgeons will be grouped as Halifax surgeons, Cape Breton urban surgeons, and all other surgeons. Other specialties will be grouped according to the Provincial Medical Board specialty listing with the possible exception of those specialties with a small number of physicians which will require special consideration. The Medical Review Committee has established that General Practitioners will be categorized in the appropriate Provincial Medical Board specialty if 60% or more of their MSI payment, in the latest fiscal year, was generated by services related to that specialty. An example of this would be a G.P. whose major portion of his M.S.I. payments are for anaesthesia. Conversely, specialists with less than 40% of their MSI payment, in the latest fiscal year from their specialty, will be assigned to a second peer group in addition to their specialty peer group. An example of this would be a certified surgeon whose major portion of MSI payment is for non-surgical services. These groupings will be flexible and will be established on April 1st of each year. Once the doctor has been placed in a group, he will

*Medical Director, Maritime Medical Care Incorporated.
**Associate Medical Director, Maritime Medical Care Incorporated.
***Director of Statistics, Maritime Medical Care Incorporated.

msi PHYSICIAN PROFILE	SPECIALTY	LOCATION	NAME	DR. NO.	PEER GROUP
For 12 months ending Dec 31/73	00 Family Practice	19 Anytown	Dr. J. J. Jones	0000	XJ

TOTALS			FEE GROUP AND ITEM	INDICES			
SERVICES	PAYMENTS	PATIENTS		SERVICES	PAYMENTS	PATIENTS	PSI
12,069	55,123	1,977	TOTAL	156	132	98	160
20	255	19	001 Major Consult G.P.	126	126	120	143
5,970	25,363	1,544	103 Office Visit G.P.	153	153	100	156
12	51	10	105 Well Baby Care G.P.	18	18	25	26
698	4,138	331	121 Day Home Visit G.P.	166	166	138	171
76	638	69	123 Night Home Visit G.P.	73	72	71	73
72	612	61	125 Emergency Visit G.P.	243	242	220	305
117	986	115	127 Sunday & Holiday Visit G.P.	132	131	137	135
114	291	71	129 Extra Patients - Home G.P.	300	307	251	348
135	574	144	151 Initial Hospital Visit G.P.	319	319	316	334
4,013	12,615	298	153 Subsequent Hospital Visit G.P.	215	210	185	221
128	326	46	201 Injections	81	81	55	83
112	285	11	202 Hyposensitization	37	36	24	43
21	89	25	249 All Other List I	177	175	229	229
188	799	186	251 Pap Smear	124	124	136	128
15	191	13	252 Sigmoidoscopic Exam	119	114	105	143
33	140	33	255 Vaccination	131	132	134	148
25	319	14	299 All Other List II	70	78	58	72
26	2,060	26	301 Normal Confinement	73	72	73	81
56	213	25	311 Newborn & Premature Care G.P.	80	66	69	91
5	213	5	321 Diagnostic D & C	76	77	75	115
1	21	1	324 Abortion, Incomp. or Therapeutic	22	9	23	37
6	638	6	423 Appendectomy	166	166	166	551
1	32	1	429 All Other Dig. Tr. Surg. over $50.	58	23	58	158
2	102	2	461 Adult Tonsillectomy	55	54	52	120
4	191	4	472 Fractures over $50.	78	54	76	91
1	21	1	479 All Other Orth. Pro. over $50.	38	11	38	103
16	82	16	501 Incision & Drainage Abscess	166	131	170	173
14	230	13	506 Biopsies	291	261	282	387
2	27	2	511 Excision Sebaceous Cyst	37	36	37	45
23	247	22	526 Excision of Warts	88	75	88	94
42	357	42	531 Suture Lacerations	84	83	85	86
1	34	1	546 T & A (under 16)	7	7	7	18
17	493	17	551 Fractures ($50. and under)	126	135	126	136
10	94	10	561 Circumcision	90	87	90	110
6	142	6	599 All Other Minor Surgery	23	41	27	25
50	1,741	53	600 Surgical Assistant	105	109	109	110
25	357	24	901 Detention Fee	74	105	123	121
2	47	2	905 Independent Consideration	55	47	57	76
3	51	3	909 Group Immunization	51	47	130	119
7	60	6	951 All Other Services	152	150	133	183

TABLE I

remain in it for that year. At the present time about 200 physician peer groups have been established.

B. Fee Group — is the grouping of related fee schedule items into manageable groups for statistical display. It is readily understandable that it would not be practical to prepare a profile with each individual fee schedule item displayed as there are in excess of 3,300 items in the Fee Schedule. There are 130 fee groups.
When a physician is sent his profile, an accompanying letter will provide the make-up of the various fee groups.

C. Indices — these are the crux of the profile. It is the means by which the physician himself, and the Medical Review Committee can compare him with his peer group.
An index is a statistical measure. It is a relative averaging number which is used to make comparisons. The base or starting number is stated as 100, meaning 100%.
In the profiles, the base or start of each series of index numbers used is the average number of services rendered, the average amount paid, the average number of patients seen, and the average number of services per patient for all physicians in a peer group in the most recent calendar year. Thus, when reading the profile, it is important to remember the index is used to measure one physician's performance against the average performance of his peers. Also remember that 100 represents the calculated average of his peers, which is the base of the index.
The profile uses four indices — the payment index, the service index, the patient index, and the patient-service index.
Of these it is particularly important to point out that the Patient Service Index (PSI) is a relative averaging number used to compare the number of services per patient for a single physician relative to the number of services per patient for all physicians in the peer group. This index has the effect of equating different values of practice and removes the variable of the size of the practice when making comparisons between physicians.
Stated another way, the advantage of the Patient Service Index is to enable comparisons to be made of patient-service ratios regardless of the number of patients seen by the physician.

Now to discuss the profile shown (see Table I). This profile displays the practice of an imaginary Dr. Jones for the calendar year 1973. It shows that Dr. Jones is a General Practitioner who practices in Anytown. His peer group number is "XL" — that is all General Practitioners practicing in communities with a population ranging from 10,000 to 34,999 who were paid $15,000.00 and over in the 1973-74 fiscal year. The total columns on the left indicate the actual number of services, the dollar value of the payment made, and the number of individual patients on whose behalf MSI payments were made to Dr. Jones during the calendar year for his practice as a whole, and for each fee group. For example, Dr. Jones was paid $25,363.00 for 5,970 office visits he provided to 1,544 patients in 1973. He was paid $12,615.00 for 4,013 hospital visits he provided to 298 patients in the same year.

The centre column, headed "Fee Group and Item" displays the fee groups which include those fee schedule items for which Dr. Jones provided a service and was paid by M.S.I. These are the only fee groups which appear on his profile.

On the right are the previously mentioned indices and you can see that Dr. Jones has a total Patient Service Index (PSI) of 160. The interpretation is that Dr. Jones provided 60% more services per patient than the average physician in his peer group. The service index of 156 shows he provided 56% more services than the average number of services for his peer group. His payment index of 132 shows that he was paid 32% more than the average of his peers while his patient index of 98 shows that he had 2% less than the average number of patients. Just as readily, other indices tell Dr. Jones, and the Medical Review Committee, that he was paid 26% more than his peers for major consultations, 53% more than his peers for office visits, 142% more than his peers for emergency visits. On the other hand, he provided fewer obstetrical services than his peers and he does very little surgery.

The profile also shows that Dr. Jones derived 83.3% of his MSI income from five fee groups — 103, 121, 153, 301 and 600. It follows that the Medical Review Committee would concentrate on these areas which constitute the bulk of the doctor's practice in their review of his practice. It is noted that Fee Group 103, office visits, has a PSI of 156. The service index of 153, along with a patient index of 100, suggests that Dr. Jones may be overservicing certain patients. Similarly, Fee Group 121, day visits (8 a.m. to 8 p.m.) with a PSI of 171, a service index of 166 and a patient index of 138, suggests, again, the possibility of overservicing.

With the introduction of the new profile, the Medical Review Committee has established arbitrary criteria which will cause the Committee to review that particular physician's pattern of practice. Since, at present, these are only arbitrary the criteria will be subject to review from time to time as experience is gained by the Committee.

Fee Group 153, subsequent hospital visits by General Practitioners, with a PSI of 221, correlated with a service index of 215, a payment index of 210, and an 85% greater than average patient index, suggests that a closer examination should be done on this aspect of his practice.

Fee Groups 501, incision and drainage of abscess, and 506, surgical biopsies, have PSI's which exceed the Medical Review Committee's criteria. However, on examination, we see that in Fee Group 501 only 16 services were performed, and in 506, 14 services.

A review of the Peer Group Profile will tell the Medical Review Committee that there are 42 physicians in Dr. Jones' peer group and they provided only 264 services in Fee Group 501 and 95 in Fee Group 506. This, coupled with the small payments to Dr. Jones in these fee groups, allows the high PSI in these instances to be disregarded.

The Medical Review Committee is a representative group of physicians appointed by the Medical Society of Nova Scotia who consider each to be knowledgeable in his field of practice. This intuitive knowledge and recognized good judgment, combined with the objective data of the profile, will be used in determining what action, if any, is to be taken regarding further study of a particular physician.

The profile is the main thrust of System I of the Physician Data Reporting System and is intended, primarily, as a screening process for the Medical Review Committee. However, it is hoped that it will provide useful information to the physician concerning his pattern of practice.

The profile will be used by the Medical Review Committee as a means of selecting out those physicians whose pattern of practice might be subject to closer scrutiny.

Further study, when requested by the Medical Review Committee, will come under System II of the Physician Data Reporting System. This will entail study, in depth, of those areas of the physician's practice that the Medical Review Committee directs. This may include calendar profiles, daily and/or monthly studies. System II is in its early developmental stages and is a manual process at present.

In order to ease the workload on the Medical Review Committee, it is intended that the Physician Data Management Committee act as a screening agency and review all profiles prior to the submission of selected ones to the Medical Review Committee.

We are of the opinion that a profile can be useful to a physician in addition to the practical aspects of informing him of his income from MSI for the number of services provided to the patients he has seen. He can also use this statistical display to ask himself the question why, in certain fee groups, does he differ from his peers. Also, the profile should be a valuable guide or indicator to the physician in identifying those areas in which he may wish to take post-graduate training, i.e., those areas of his practice in which he provides the majority of his services.

Maritime Medical Care will be pleased to send you a copy of your Profile. To obtain yours, make a written personal request to the Associate Medical Director of Maritime Medical Care Incorporated, P.O. Box 2200, Halifax, Nova Scotia, and ask that your current Profile be sent to you.

The Profile will be sent by Registered Mail to ensure that only you receive it and with it will be explanatory information to help in its interpretation. □

Physican Self - Assessment

Lea C. Steeves, M.D.,
Halifax, N.S.

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

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

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

3. A 44-year-old Wisconsin dairy farmer is seen because of dyspnea and non-productive cough for the past three winter months. The patient states that he has had similar difficulty during the winter months for the past five years. This condition has become progressively worse each year. The patient denies disability during the summer months, but he says his ability to do strenuous exercise is somewhat curtailed by "short wind".

   For the past three years, he has had bouts of severe dyspnea, cough, and fever whenever he fed his livestock. Last winter, while on a prolonged vacation to the southwest, his chest condition improved markedly.

   Physical examination at this time shows scattered crepitant rales throughout both lungs.

   Which of the following is the most probable diagnosis?
   (a) Silo-filler's disease
   (B(Pulmonary aspergillosis
   (c) Endobronchial tuberculosis
   (d) Hamman-Rich syndrome
   (e) Farmer's lung

(Please turn to page 186 for answers) □

AN INDIVIDUAL VIEW OF ACUPUNCTURE IN CHINA

Continued from page 172

sure on the patient to follow the method, from the doctors, nurses and the whole organization of the Centre. This is supported by the patients own convictions gained from reading books, articles and by word of mouth. The results in such centres are very similar to those reported for acupuncture: 10% or less experience no pain, 80% experience varying degrees of pain from slight to almost intolerable, and 10% are failures in that they opt out of the method in spite of all persuasion to the contrary. The difference between natural childbirth and acupuncture for surgery lies in the reward of a healthy baby for the mother, whereas for acupuncture the reward is less tangible and is in part ideological.

SELECTION OF ACUPUNCTURE POINTS

There is nothing haphazard about the selection of acupuncture points for various operations, although different principles are favoured by some schools, leading to differences in method. There are four principles to choose from:

1. **Meridian Theory**

According to Chinese traditional medicine, there are 12 paired meridians, and two unpaired meridians, or channels on the surface of the body, through which the life force, or **Chi,** is connected to the hollow or solid internal organ which it governs. The Ching or meridians and the Lo — the lateral branches between meridians, result in this principle being called the Ching-Lo theory. The 365 classical acupuncture points on these meridians may be all used in the treatment of disease, but certain points have proven themselves more effective in providing sedation or analgesia than others. These are generally located on the ventral or lateral aspects of extremities, those of the upper limb being preferred for operations on the trunk and thorax, and those of the lower limb being preferred for abdomen, pelvis and inguinal region.

2. **Neurophysiological or Segmental Approach**

This utilizes known acupuncture points in the cutaneous dermatome to be operated on, usually through a paravertebral approach, and is often combined with para incisional needles, to give more direct dermatome analgesia to the skin.

Sometimes the meridian and segmental approaches are combined, the segmental approach being relied on to produce skin analgesia, and the meridian theory to control traction responses from the operated viscus or viscera.

3. **Ear Needling**

This theory states that because of the complex multiple innervation of the ear, every point on the body is represented on the ear, and that acupuncture in the appropriate point or points, can provide analgesia wherever it is required. Not only did I see craniotomies, eye procedures and other head and neck surgery performed under analgesia induced in this way, but also saw a partial gastrectomy performed under ear needling.

4. **Nose or Face Needling**

This theorizes that because of the sensitivity of the face, and especially the nose, portions of the body are represented on the nose and forehead: needling of these areas can produce analgesia for surgery in the appropriate area. I saw a bilateral oophorectomy carried out under nose needling, with two needles at the ovarian point, one at the uterus point, and at the small intestine point, and others in general sedation areas.

METHOD OF STIMULATION OF NEEDLES

Traditional acupuncturists excite or sedate meridians by the amount of lift and thrust applied to the needle, and the direction and extent of rotation applied to it, and the duration of application of the stimulus. Sometimes needles are inserted and not manipulated. I saw a radical neck dissection and hemimandibulectomy, a parotidectomy and a mandibular tumour removed with two needles inserted into each leg, neither being stimulated in any way. The lift and thrust combined with rotation through one needle in the forearm was the sole anaesthetic used for two lobectomies seen.

However, the more usual method was to stimulate the needle electrically with an electric stimulator once it is in position: very rapid rates of stimulation up to 60,000 per minute, occasionally with a crescendo-decrescendo pattern are used in head and neck needles and in para-incisional needles, while needles in extremities were usually stimulated at 90-180 times per minute.

SURGERY

Induction time is 20-30 minutes, although it may be shortened to between 2-15 minutes in certain dental and ophthalmic procedures. Most patients are premedicated with 100 mg of phenobarbitone, and most major cases received 50 mg of meperidine intravenously immediately prior to incision. This did not cause any nausea, or obvious respiratory depression, though it frequently made some patients a little drowsy at incision time. 1% procaine infiltration of peritoneum, of mesentery, or of an intercostal nerve prior to rib resection was occasionally used.

It was fascinating to see a conscious patient stop breathing at the onset of cardiopulmonary bypass, and to hear her answer questions after her heart was stopped in fibrillation.

To see all this surgery under acupuncture is most impressive, even for the experienced anaesthetist, and I feel that our Chinese medical colleagues deserve full credit for their innovation and persistence in this field. It is also true that major surgery, especially open-chest procedures, were a major stress for these patients, blood pressures rising, and pulse rates often reaching 140-160 per minute. The monitoring of blood gases and oxygenation was the exception rather than the rule, and at least two patients appeared clinically hypoxic towards the end of open-chest procedures. It should be squarely stated that these changes settled very rapidly on closure of the chest and reinflation of the lungs, and that the patients came off the table certainly no worse than our conventially anaesthetised patients, and perhaps better, since they were conscious and cooperative, able to deep breathe and cough on command. That strabismus patients are able to move their eyes on command, and that menisectomy patients are able to straight-leg-raise immediately post-operatively are other advantages noted.

APPLICATION OF ACUPUNCTURE IN CANADA

In Western society, with modern anaesthetic techniques, patients show general acceptance of the concept of unconsciousness during surgery. We have excellent local anaesthetic drugs and techniques for providing painless surgery under good conditions in the conscious patient, yet few are prepared to accept local or regional anaesthesia. The question arises as to how many would accept the discomfort of acupuncture analgesia, in the absence of any clear-cut evidence of advantage in safety or reduced morbidity. Since we cannot obtain such evidence from Chinese sources, because of their reluctance to carry out controlled trials, the only way to secure it is to ask surgeons to cooperate in a project to encourage patients to volunteer for surgery under acupuncture analgesia in an investigational protocol which would critically assess postoperative morbidity in such patients and compare them with a group of matched controls under conventional techniques. This process of assessment will take time, so that we cannot look to acupuncture analgesia becoming an accepted technique for at least a year or two.

Similar considerations apply to acupuncture therapy, in that clear evidence of its therapeutic effectiveness and reliability is lacking. However, public acceptance of this procedure for chronic ailments is enormous, and the pressure is on the medical profession to provide an immediate service in response to a present need. It is certain that if these needs are not met by the medical profession, non-medical practitioners of acupuncture will be encouraged, and will proliferate, whether in legalized or in undercover clinics, at great expense to these patients, who will also run the risk of having treatable conditions neglected.

The Department of Anaesthesia at the Victoria General Hospital has been running a pilot project to assess the effectiveness of acupuncture in various types of chronic pain syndromes during the past nine months, and has now incorporated this into a Pain Clinic, operating each afternoon in the Outpatient Department.

Although it is too early to give an assessment of which disorders respond to acupuncture, and to what extent, it is clear that many patients, after treatment, derive substantial benefit which can persist for useful periods of time.

The next step to be taken in cooperation with interested departments and subspecialties, is to carry out selective studies on patients with clearly defined entities, such as hemiplegia, paraplegia, essential hypertension, rheumatoid arthritis and asthma, to demonstrate whether the addition of acupuncture to conventional treatment provides any objective benefit.

Dr. John Bonica, an eminent authority on the treatment of pain, states that the United States National Institute of Health ad Hoc Advisory Committee on Acupuncture, "after reviewing the evidence and experience of some of its members with acupuncture therapy and acupuncture anaesthesia . . . concluded there was sufficient evidence to suggest that acupuncture deserves serious scientific study". He concluded that the misuse of therapeutic acupuncture is an important health problem, and that the widespread clinical use of acupuncture is not warranted at the present time. He believes, as we do, that there is a need for well designed carefully controlled studies to evaluate acupuncture before it is made available to the public at large. □

Reference

Bonica, J. J., Therapeutic Acupuncture in the Peoples Republic of China, J. A.M.A. (June 17) 228:1544, 1974

The doctor and his "leisure"

A Visit to China

Ian E. Purkis,* M.B.B.S., F.F.A.R.C.S., F.R.C.P.(C),

Halifax, N.S.

China has a fascination for most of us, conjuring up pictures of ancient civilization, traditions, and a culture completely different from our own. That it has been difficult and rare to be able to visit modern China until recently makes the opportunity one not to be missed.

All intending visitors to China read voraciously, and learn the landmarks of that country's recent history. A once proud people, who considered their country to be the centre of the world, stripped of their grandeur by the trade wars of the late 19th century, felt a deep sense of humiliation and loss of nationhood. The impetus to change, reform and modernization which began with Dr. Sun Yat Sun, foundered in the corruption of the Kuomintang era.

The small guerilla bands of the Peoples Liberation Army built their success on a code of conduct that was puritan and egalitarian, and their integrity was in such obvious contrast to the corruption of the official regime that a revolution was inevitable. 1949 is referred to as the Liberation, and in the twenty-five years since then, Chairman Mao Tse Tung has emerged as an almost god-like figure, whose "sayings" govern the everyday conduct of each individual, and give them a sense of nationhood and pride in the progress that has been made. Through the major unheavals of the Great Leap Forward, The Cultural Revolution of 1965-67 and the present mini-revolution or campaign against Lin Piao and Confucius, not only has Mao Tse Tung reaffirmed his position as spiritual leader of the revolution, but he has maintained or revived the revolutionary zeal of large sections of this immense population.

The intense curiosity in the West about what goes on in China stems in part from the secrecy surrounding the Chinese leadership and its programme. The Peoples Republic of China has had good reason in the past to be suspicious of the West, and their revolutionary pride has made them want to go it alone. Unsure of how their programmes would turn out, they have been reluctant to publicize them until their success has been obvious. This reluctance and suspicion has also been reflected in the small numbers of visitors allowed into the country, and in the absence of hard news in their official newspapers, details of events being published months or years later.

It was with a feeling of intense excitement, interest and curiosity that I joined other members of our delegation of anaesthetists in Ottawa for briefing. We flew from Montreal to Paris, then left the following evening for Peking via Karachi. We landed at Karachi at 8:00 A.M., the airport ringed by armed soldiers. Over China, we were told that our cameras could not be used, and we watched the desert greys, browns and yellows of Pakistan change slowly to the hill country of Northern India and Tibet. Tantalizingly for the last two hours of our flight, the ground was obscured by cloud, and we started our descent to Peking through the thick brownish yellow clouds of one of the frequent sand and dust storms that come in from the nearby desert. At 6:30 P.M. on April 5th., we landed in Peking, and opened our eyes to a kaleidoscope of early impressions.

Dr. Bethune's Statue in front of the Norman Bethune International Peace Memorial Hospital, Shia Sha Jang, Peoples Republic of China.

Walking into the airport, the balcony was crowded with onlookers, many, both women and men, in the green of the Peoples Liberation Army, but most in greys or blues, and all dressed in the uniform style popularized by Mao Tse Tung, whose benign picture hung over the entrance. In contrast to Karachi, no one seemed to be carrying arms. Lining up for customs, our passports disappeared into the hands of the officials who were to meet us and escort us throughout our stay in Peking. We were led upstairs to a lounge area, where introductions were made after tea had been brought, then, after a brief speech of welcome, we were driven in limousines through the darkness to our hotel.

*Professor, Department of Anaesthesia, Dalhousie University.

The hotel, built in a heavy Russian style, had red carpeted hallways, gilded columns, and ornate gilded lanterns in the main lobby. Taken up to the sixth floor by the elevator operator, a girl, we were assigned rooms after consultation with the porter in charge of the floor. The rooms were comfortable and large, with worn rugs on a hardwood floor, and furnished with heavy furniture, covered with cotton overcovers, and lace antimacassars. On the glass topped table stood a carafe of boiled water, topped with a glass, and a tin of tea. The bathroom had a full bath and toilet, and ancient white tiles, with a poorly made wooden cabinet for toiletries, but all the plumbing worked, and the water was hot and very welcome after the long flight.

With the twelve hour time change, I was awake at first light, around 4:30 A.M., and found my room looked out on the broad main street of Peking, wide enough for 8 lanes of traffic and decorated with street lights each having eight white globes arranged in a pyramid. I watched the stream of bicycles grow steadily thicker and at 5:00 A.M., long lines of marching children, carrying wreaths and red banners, beating drums and singing songs, began to march past, marshalled with bullhorns by their teachers and group leaders. They were headed for Tien An Men Square (Gate of Heavenly Peace) where their wreaths would be laid at the monument to the Revolutionary Martyrs. Later in the morning, our first sightseeing expedition took us to this square, an enormous expanse, capable of holding 250,000 people, and flanked on the one side by the Great Hall of the People, and on the other side by the Museum of Revolutionary History.

We were proudly told that the Great Hall of the People had been built in a year, and that 5,000 guests would sit down to dinner there on state occasions, as when President Nixon and Prime Minister Trudeau made their visits. The enormous square, these buildings, and the broad main street had all been cleared and built in the last 15 years, the former occupants of houses removed having been relocated to modern apartments. It has made the Tien An Men gate even more impressive as an entrance to the Forbidden City, which flanks the northern end of the square, and the gate also doubles as a reviewing stand for parades.

The Forbidden City is in sharp contrast with the modernity of the square. Entering through the gate through a stone passageway about 150 yards long, one is brought face to face with ancient China and all its traditions. Built by emperors of the Ming dynasty 600 years ago to keep out the common people, it is now a popular sight-seeing attraction open to all. Like most ancient monuments in China, an opportunity is taken to emphasise both that these were built by the skill of the Chinese labouring peoples, and that their cost was out of proportion to the gross national product of the time. In the two afternoons available, we were only able to see a small proportion of this city within a city. One walks across an enormous courtyard to a pavilion, passes through that, down marble staircases carved with dragons and storks, to the next courtyard and the next pavilion. After the six main pavilions, you reach the living quarters of the Emperor, the Empress, and the concubines, which at one time numbered over 200. The Forbidden City houses the Chinese Cultural Relics, displaying artifacts dating from 4000 years B.C. to the 18th and 19th Centuries. Perhaps the most impressive relic is a funeral mantle made for a priest-prince 1500 years B.C. covering the entire body, and consisting of square plaques of jade sewn together with gold wire. The early percussion instruments like xylophones, made of bronze tubes or stone plaques are interesting, and there is a bewildering variety of jade carving. Horses cast in bronze were lifelike in 700 A.D., especially the flying horse, so fast that only one foot resting on the back of a swallow forms the pedestal. The most touching item was a set of gold ornaments for a child, of animals in almost line drawing style.

The following day, a Sunday, we visited Fragrant Hill Park, along with thousands of others having their day of rest. In China, the work week is six days, and the working day is divided into two four-hour periods by a two hour break for lunch and a rest. As many factories work shifts, there are always thousands of people on the streets and in the shops during working hours, but there are many more free on Sundays. The day of rest is usually organized, and groups from factories, schools and communes are the rule rather than the individual sightseer. Sightseeing is usually combined with political instruction, or your group may volunteer for labour in many projects. The Red Guard Youth Organization arranges trips to various park areas, and combines them with drills and exercises in the martial arts of sword play, stick fighting and wrestling, a little like the Kung Fu we see on television in the West. Nevertheless, we met many individual families strolling through the wooded pathways, some with cameras, and some with transistor radios. Here also, for the first time, I noticed some individuality of colour in dress, particularly among the children.

Photographing presented many difficulties: the Chinese press had carried strong criticisms of the Antonioni film just prior to our visit, and all Chinese were very aware that foreigners could produce biased pictures of the New China through photographs. It was polite to ask our hosts for permission to photograph, and this was rarely refused, though we were sometimes asked why we wanted to photograph a particular scene. In photographing people, our hosts insisted that permission had to be obtained from the individual photographed, and almost everyone was camera shy and refused. When photographing a building, crowds would melt mysteriously, so that most of our scenes look curiously deserted. I must admit that the temptation to photograph the curious and the ancient, rather than the modern, is particularly strong in the first two weeks in China, and one's fingers itch to capture the beautiful faces of children, old men, and old women with bound feet, the donkey and mule carts, and the bamboo baby carriages. Much of the modern architecture is not especially photogenic, being very functional, but the air of the revolutionary joy on the faces of some of the young men and women would have been well worth capturing. For this, we had to rely on some of the propaganda material made available to us free in the hotels.

The requirement to ask permission of an individual before photographing is an important part of the Chinese sense of courtesy and politeness. While this sense introduces an extreme formality into most relationships, it does underline the

need for privacy which is so important in such a crowded land, together with a respect for the rights of the individual which was a major surprise for me to observe in a communist country. During a visit to a military hospital, a young soldier patient being treated with herbal medicines for gallstones, refused to have his picture taken showing the gallstones which had been salvaged carefully from his stools. There was no question of our hosts ordering him to be photographed, but three of them sat down with him to reason with him, and to criticize him for his lack of politeness to their distinguished guests. After ten minutes of this, in spite of requests from us that they desist from persuasion, the poor lad was brought to see the error of his ways and the disgrace he was bringing on the hospital and the health officials of the city, and finally consented. However, we thanked him very profusely and said we respected his right not to be photographed.

This incident occurred in Shia Sha Jang, a city of 80,000, where Dr. Norman Bethune founded a wartime medical school in 1939, and where a memorial and a museum are maintained in his honour. It is difficult to convey the extent and depth of the regard that the whole chinese people hold for Dr. Bethune and through him, for all Canadians. His brief life of 19 months in China brought about a complete revision of medical care in war conditions, which saved the lives of tens of thousands in the later years. His life in China is completely documented with pictures, letters, and articles written by him, and he is held up as an example of selflessness and dedication by no less an authority than Mao Tse Tung, who not only gave his funeral oration, but wrote an essay on his internationalism. This essay on Dr. Norman Bethune is included in the Little Red Book, which is known by heart by all chinese. In a youth centre in Shanghai, we pointed to a picture of Dr. Bethune and asked a 12 years old girl who it was: back came the answer instantly "Baychouan".

His tomb occupies one quadrant of a huge cemetary in Shia Sha Jang, dedicated to the Revolutionary Martyrs, the raised marble mausoleum on a semicircular dais surrounded by pictures of his life, and fronted by an impressive 12 foot high statue of him in white marble. Our delegation was privileged to be able to lay a wreath at this tomb on behalf of Canadian doctors.

Peking and its surroundings encompass more historical sites than almost any other city in China, since it has been the capital for over 800 years, except for a very brief period during the Kuomintang rule, when the earlier capital of Nanking was reinstated. The Temple of Heaven lies in the southern part of the city and is an impressively ornate circular temple about 270 feet high. Its gilded painted exterior has been recently restored by 200 craftsmen working for 8 months. The Summer Palace lies on the northeastern outskirts of the city, built on a man made hill 300 feet high, the excavated area forming an artificial lake several miles in circumference. The various palaces, pagodas and temples of the Summer Palace are set in beautiful gardens, and row boats, sampans or launches can be hired for an afternoon cruise on the lake. The Buddhist period of China is also preserved, and the Temple of the Sleeping Buddha close by Fragrant Hill Park, contains an enormous carved, painted and gilded statue of the Master surrounded by 12 foot high statues of warriors and councillors.

No visit to Peking is complete without seeing the Great Wall. Originally nearly 2500 km long, most of it is in crumbled disrepair, but a 5 km section has been restored as a tribute to the genius of the chinese labourers who built it. It lies about 40 km northeast of Peking, in a mountain range which narrowly separates China from Russia. The Chinese in Peking are very conscious of the close presence of the Russians, and we were told that the Russians are only an hour away from Peking. On the day of our visit, our third Sunday in Peking, the Wall was crowded with Chinese groups and families, and along with them, we struggled up the incredibly steep climb to the topmost bastion. The weather was misty and cold, but the exertions of the climb soon had us perspiring and kept our hearts pounding. Because of the mist and cloud, we missed seeing the spectacular views that are depicted in pictures and tapestries throughout China.

Dr. Norman Bethune performs surgery in a Temple, China, 1939.

On our way back from the Great Wall, we visited the Valley of Tombs, where 10 of the 13 Ming Emperors are buried. Only one of the tombs has been opened, as the entrances are cunningly hidden, and this yielded a fantastic store of gold in coins, ingots and ornaments, as well as furniture and potteries. 35 feet underground four long tall chambers are connected by corridors to form a cross. A new entrance has been made, but one leaves by the former entrance, passing the massive marble doors which, once closed behind the funeral party, locked automatically with massive stone blocks. Signs in the tombs pointed out that farmers had been driven from their land by force to make way for the tombs, and that this tomb had cost more than the entire gross national product of China for two years in the building.

Leaving the Valley of the Tombs, one passes along the avenue of statues, a mile of straight road leading from the entrance gate, and lined on each side with massive marble

statues of warriors, councillors, elephants, camels, lions, tortoises and legendary beasts. This traditional entrance way to the tomb area is also found in Nanking, where two earlier Ming Emperors are buried.

In Nanking we also saw the Sun Yat Sen memorial completed in 1929, which is in the same architectural tradition as the Ming tombs, but approached by an impressively steep flight of 390 steps. Set in a wooded hillside, the tomb is entered by a gate bearing in chinese the words which inflamed the hearts of the people and led to Sun Yat Sen being honoured as the founder of the revolution. The inscription reads "All men are equal under the sun". Inside the tomb, the sarcophagus is set in a round well in much the same manner as Napoleon's tomb in Paris.

Nanking is also famous for its bridge across the Yangtze, over 1000 yards long, with raised road and rail approaches that are four and six miles long respectively. After the bridge was designed, the Russians withdrew their offer of the special structural steel required, and the Chinese had to learn an entire technology to produce this steel themselves. Our special guided tour was conducted by two attractive 18-20 year old girls, who presented all the statistics with great confidence and competence.

Nanking was the most politically active city visited, wall posters being everywhere in evidence, and some had obviously been torn down and pasted over by groups putting forward a different view. On one occasion, we ran into a noisy demonstration completely filling both sides of a large boulevard. Not wishing to embarass us, our hosts ordered an abrupt U-turn and after a detour through very narrow poor streets, which we otherwise would not have seen, we were returned to our hotel. On the day of our departure, just before the May Day holiday, we followed a long detour through the city park, called Lake of the Five Islands, which we had visited earlier. The islands contain gardens, recreational areas and a zoo where giant pandas, oriental tigers and bears were prime attractions. Our hosts were evidently worried lest some trouble should erupt on the normal route to the station, and their concern was amplified when our cars were surrounded by crowds of thousands at the station, so that they had to plead for a pathway for us to escape to a waiting area, which was immediately closed off by police and isolated by pulling down all the shades. Twenty minutes later, when we came to board the train, the crowds if anything had increased, but were now all smiles, and applauded us over the 700 yard walk to the train.

The trains in China were excellent, the coaches being convertible into four berths at night, with ample luggage and storage space. They ran on continuous welded rails, and were always on time. Tea was served in the compartment on short journeys, and on longer journeys, the restaurant car provided excellent six or seven course meals. In the south, the trains were air conditioned, and all carried specially timed tapes of patriotic songs, interspaced with introductions to the next station that was being approached, along with exhortations to follow the sayings of Mao Tsu Chi (Chairman Mao). These were carried over loudspeakers in each carriage, but an individual volume control was available.

Air transportation is also excellent, but most of the travellers are officials or military. We flew from Peking to Nanking in a Russian-made turbo-prop plane reminiscent of the Vanguard, and from Hang Chow to Canton in a tail-engine jet similar to the DC-9 in size and comfort. Announcements were made in Chinese and English: shortly after take off we were informed that "It is strictly forbidden to retain guns or explosives while on board the plane, all such items must be handed to the stewardess for safe-keeping, and will be returned at the end of the flight". Since most airports house military as well as civil aircraft, the use of cameras in flight was also forbidden. No alcohol is served, but tea is available in flight, and complimentary sets of post cards are given out, as well as chewing gum on take-off or landing.

May Day in Shanghai was an unforgettable experience. The usual parades had been cancelled for fear of demonstrations, but we were taken to a large park, in sections of which were set five stages at which various groups of dancers, singers and orchestras were performing. The dancers were from various factories or labour groups, and most of their dances illustrated how they enjoyed working for Chairman Mao and the revolution in the cotton mills or as longshoremen, etc. Some were gymnastic displays and some were displays of martial arts, a sort of ritualized combat, often casting girls in the role of heroine. Balloons and streamers flew high in the air and floats on the lake depicted goldfish and other traditional objects. Stools were reserved in the front rows before each stage for foreign visitors, and as each group entered or left, often during the performance, they were loudly applauded by the audience, and as is customary, clapped their appreciation in return.

In the evening we saw a performance by the Shanghai group of acrobats, by far the most polished group of a brilliant series of troupes that we had seen in Peking and Nanking. The acts and music are traditional, but the expertise of the company and the variations given to each act can be very different. At all performances we attended, television cameras were at work, so that this would be one of the major entertainment items of the Television Network.

Following the show, we were driven through the illuminated streets of Shanghai, so densely packed with crowds that there was scarcely room for our cars to pass. In an hour, we covered about eight miles of streets lit with strings and arches of 25 watt bulbs, and throughout the length of this triumphal procession we were cheered and applauded, smiled at by teenagers, mothers, fathers and grandparents. Babies in arms were thrust towards the car to see the foreign visitors, and in that hour I must have met 100,000 people eye to eye, and there must have been well over a million people in those streets.

After a busy schedule in Shanghai; we were allowed a weekend of relaxation in the beautiful city of Hang Chow, staying in a massive hotel in beautiful grounds overlooking the West Lake. The lake is the city's principle attraction, about three miles in diameter, with a circumference of 15 miles, it is bordered by the city on the east, ringed with low hills on the remaining sides, and dotted with islands. Beautiful parks open onto the lake, and the lake shore drive in the city is set with willows and pagodas in the traditional Chinese style. We spent

a relaxing afternoon cruising the lake, strolling through the parks, and visiting a Buddhist Pagoda a few miles away, which contained an impressively large carved wooden figure of the seated Buddha, over 100 feet high, and at least 1100 years old. We also visited a tea plantation and a silk weaving factory before flying to Canton.

Like Shanghai, Canton had been one of the former treaty ports, and had been extensively industrialized since the liberation. Only three hours by rail from Hong Kong, the city receives buyers from all over the world for the Canton trade fair, held in the Spring and Fall. We visited the Spring fair, at the permanent exhibition site built with Russian help in the massive Russian style. We saw not only the traditional exports of silk, jade, and ivory, but heavy and light machinery, electrical and medical instruments, drugs, herbs, and a wide variety of agricultural produce, including beer, wines and liqueurs.

Since my return, I have often been asked what we ate or drank in China: Was the food really like Chinese food we eat in restaurants in the West? Substantially it was, especially at official banquets, where 16-18 courses were often served, but there was a great variety in dishes between regions. At our hotels, we were offered western food, but preferred the Chinese, and ate with chopsticks without difficulty after the first week. At lunch or dinner a whole fish or a whole duck or chicken cut to chopstick size would be served, along with very lightly boiled vegetable dishes, and a mixed dish more like "Western" chinese food. A choice of beer or orangeade was served with the meal at the hotel, but at banquets, three glasses were filled in front of you; beer or juice, wine and a liqueur glass containing grain alcohol, called Mau Tai. This is made from sorghum, is about 65% alcohol, and has a distinct taste between vodka and gin. Fortunately, it is reserved for official toasts, but one is expected to empty one's glass at each toast. The wines are all very sweet: usually we were served red wine, but once a rice wine tasting like a sweet sherry was offered, and we did try Chinese champagne, which was light and sweet, but very pleasant. The beer was excellent everywhere, but that from Tsintao was the best. Whisky and Brandy is also available, but are not recommended, though I did not try them myself.

It is hard to give an overall impression of China and its people, for though I spent six weeks there, and was much less restricted in my movements than some of the Canadian students we met in Peking, I saw only a small fraction of a very large and populous country. Knowing the devastation that the war years had created, and the lack of industrialization prior to the Liberation, it was obvious that tremendous progress had been made. Intensive irrigation, coupled with rural electrification and farm mechanization is obvious everywhere, but China remains a predominantly rural economy, and I was repeatedly told that they are a poor country, but that the system allows enough so that no one goes hungry, or without clothes. Rice, cotton, and consumer goods such as bicycles and sewing machines are rationed to ensure fair distribution. Most houses, even in the most primitive villages, have electric light and a cold water supply. Nothing useful is wasted, and nothing is disposable, all human sewage being used as fertilizer. Massive public health education programmes have eliminated major diseases, and rats, flies, mosquitoes and parasite carriers have virtually disappeared. The enormous population has been made literate, the education system ensures an equal opportunity for all, and the people are hard working, intelligent and appear to be enthusiastic in their dedication to progress.

It is the most egalitarian society I have ever seen, not only in distribution of income and goods, but also in privilege. Those in office are continually exhorted to "learn from the masses": not to have been born a peasant is a great handicap to University education or advancement in any profession. Above all, the decentralization of all but the most major policy decisions gives each individual a voice in what happens in his own neighbourhood, factory or farm production unit, and this sense of active participation is obvious. Everyone has to participate, and would be criticized for any attempt to opt out of local decisions. It seems that the country really does function by discussion, criticism, and exhortation at the local level, and innovative solutions to local problems are encouraged.

The overall impression is one of immense dynamism and potential for expansion. Like many communist countries, their propaganda is often naive, their entertainment unsophisticated, and their standards puritanical. Although they may be suspicious of western policies and motives, the people are intensely curious about westerners they see in China, and warm and friendly in their welcome. If you are offered the opportunity to visit China, you will not regret it, and will store it, as I have, as an experience of a lifetime. □

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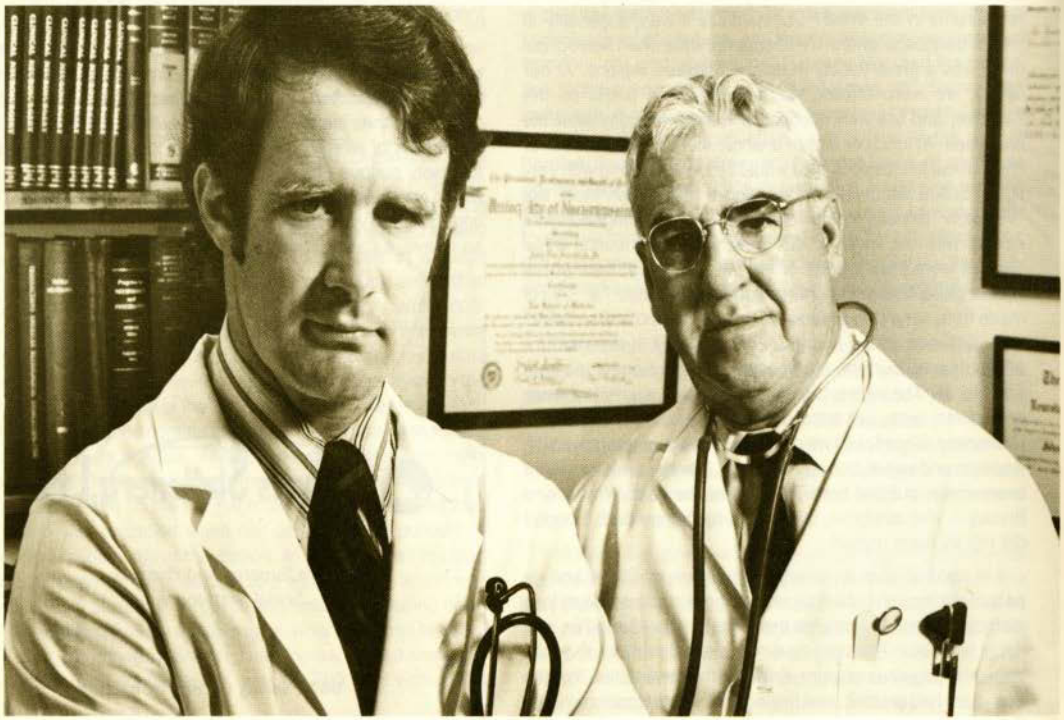

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SHALOM!

Aphorisms, maxims, adages and folk sayings abound in every language but none is richer in these than Yiddish. In the ghettos of Europe, cut off from intercourse with the rest of the world, a rich culture developed, heavily laden with irony and paradox. The following is a sample of folk sayings and moralisms related to medicine and health. They show an astonishing degree of insight into the psychogenic etiology of much disease.

"The greatest doctor is time."

"Melancholy creates diseases — which happiness cures."

"Envy is a disease that gnaws at the soul."

"The fox does not get sick from breathing the dust of his own den."

"It is a serious disease to worry over what has not occurred."

"What a fat belly costs I wish I had;
What it does, I wish on my enemies."

"Don't put a healthy head on a sick pillow."

"When the head is a fool, the body is in trouble."

"What soap is for the body, tears are for the soul."

"If you chew well with your teeth, you'll feel it in your toes."

"Don't judge a doctor; poll his patients."

"If you're not in pain, don't cry 'ay'."

"Poverty in a home is worse than fifty plagues; too much is unhealthy."

"Worms eat you when you're dead; worries eat you up when you're alive."

"The purpose of maintaining the body in good health is to make it possible for you to acquire wisdom." □

M.E.Burnstein

Correspondence

To the Editor:

I found the article by White on "The Effectiveness and Efficiency of Screening in Medical Care", published in your August number, to be both timely and thought provoking.

However, I wish to take issue with Dr. White regarding his statement on screening for cancer of the cervix, which he claims to be apparently ineffective, supporting this statement in part by a quotation from E. G. Knox[1] which was made in 1968.

A more current reference to this problem is to be found in the published summary of the recent symposium of the International Union Against Cancer[2,3]; at the conclusion of the session at which screening for cancer of the cervix was discussed, one of the participants in the panel being Professor Knox, there was unanimous agreement that:

1. "Exfoliative cytology of the cervix provides a test of value both in gynecologic diagnosis and in screening apparently healthy women, and a laboratory facility, under a trained cytologist, should be supplied wherever consultative medicine is available.

2. The use of this test as a population screening procedure promises useful yields of pre-invasive or early cancer and potential reduction in mortality. However, to realize this potential and to achieve substantial control of cervical cancer mortality there must be a well-organized service backed by a research and development effort, so that progress can be measured and the service adapted to the needs and circumstances of the particular population."

I believe that this concensus is an accurate reflection of the opinion of most authorities in the field today. All of us involved in the field of cervical cancer detection and treatment, starting with the family physician, should be aware that much remains to be done, along the lines recommended by the Symposium, before the potential reduction in mortality from cervical cancer is achieved.

Yours sincerely,

G. H. Anderson, M.B., B.S.,
Director, Cytopathology Laboratory.

References

1. **Knox, E. G.:** Cervical Cancer, in: Screening in Medical Care. Oxford University Press, 1968.
2. **Boyes, D.A., Knowelden, J., and Phillips, A. J.:** The Evaluation of Cancer Control Measures. Br. J. Cancer, 1973. 28. p. 105.
3. **Phillips, A. J.:** Summary of UICC Prevention and Detection Conference. Cancer. Supplement. 33. p. 1737.

PLAN TO ATTEND

121st ANNUAL MEETING

Hotel Nova Scotian, Halifax — November 21&22, 1974

Personal Interest Notes

Dr. Peter C. Gordon recently stated that two grants have been awarded by the Halifax Herald Limited to the Department of Preventive Medicine, Dalhousie University. These grants are for research into highway accidents and a study of hospital admission rates in the Province.

Dr. David Shephard, past Editor-in-Chief of The Nova Scotia Medical Bulletin will be returning to Canada from Rochester, Minnesota, where he has been employed in the Section of Publications at the Mayo Clinic for the past two years. Dr. Shephard will take up the position of Associate Editor with the Canadian Medical Association Journal in Ottawa. We welcome Dr. Shepard and his family back to Canada and wish him success in his new venture.

President Henry D. Hicks, Dalhousie University, announced the following Faculty of Medicine appointments recently.

Mr. David Gwyn, Professor and Head of the Department of Anatomy.

Dr. Gwyn was born in England, graduated M.R.C.S. England and Ph.D. Birmingham. Took postgraduate training at Willesden Hospital, St. John and St. Elizabeth Hospital and Royal Free Hospital in London as well as University College Hospital. Came to us after being Assistant Professor of Anatomy at the University of Western Ontario.

Dr. Brian Hennen, Professor and Director of the Division of Family Medicine.

Dr. Hennen was born in Ontario, graduated M.D. from Queen's University and took postgraduate training in Paediatrics and Medicine at the Kingston General Hospital, Family Medicine at McMaster and Medical Education at Michigan State University. Has his Certification in Family Medicine from the Royal College of Physicians and Surgeons of Canada. Came to Dalhousie after being Assistant Professor of Family Medicine at the University of Western Ontario.

Dr. G. R. Langley, Professor and Head of the Department of Medicine.

Dr. Langley is a graduate of Dalhousie University, took postgraduate training here, in Newfoundland, Toronto and Australia. Has been a member of the staff since 1962.

Dr. James A. Love, Director of the Animal Care Division and Assistant Professor of Physiology and Biophysics.

Dr. Love, was born in Northern Ireland, received his B.V.M.S. from the University of Glasgow and Ph.D. in Physiology from the University of Toronto. Has been an Instructor in Veterinary Medicine at the University of Pennsylvania and Pathologist at the Animal Research Institute in Brisbane, Australia. Came to us from the position as Director of the Animal House in the Research Institute of the Hospital for Sick Children in Toronto.

Dr. George M. Novotny, Professor and Head of the Department of Otolaryngology.

Dr. Novotny was born in Prague, Czecholovakia. Received M.D. from the University of Toronto. Took postgraduate training in Toronto and Montreal and holds Fellowship and Certification in Otolaryngology from the Royal College. Came to Dalhousie in 1967 as a member of the Canadian Armed Forces.

OBITUARIES

Dr. George Tha Din, 57, of Truro died July 4, 1974. He was born in Burma and had been a resident of Truro for the past eight years where he was a Radiologist at the Colchester Hospital. After attending Medical School in Burma, Dr. Tha Din did post-graduate work in Radiology in London, England. The Bulletin extends sincere sympathy to his widow, Dr. Joan Tha Din and his daughter and two sons.

Dr. George V. Burton, 49, of Yarmouth died August 31, 1974. Born in Boston he came to Yarmouth as a young man. He was a graduate of both Acadia and McGill Universities. He practised as an Obstetrician and Gynecologist at Yarmouth Regional Hospital. Dr. Burton was past President of the Western Branch of The Medical Society of Nova Scotia. Our sympathy is extended to his widow and family.

ADVERTISERS' INDEX

Physician Self-Assessment

Question No. 3 Correct Answer D

NEW MEMBERS

The Physicians listed below have joined The Medical Society of Nova Scotia between May 1, 1974 and September 30, 1974. A most cordial welcome is extended from the Society.

Dr. George H. Anderson	Halifax
Dr. Philip C. Bagnell	Halifax
Dr. Carolyn M. Barry	Halifax
Dr. D. Wayne Bell	North Sydney
Dr. Inder N. Bhatia	Hd. of Chezz.
Dr. George D. Blenkarn	Halifax
Dr. Walter R. Bonney	Kingston
Dr. Francis R. Boumphrey	Arichat
Dr. Wayne C. Brown	Musquodoboit H.
Dr. William D. Canham	Truro
Dr. Valentine H. Conway	Newfoundland
Dr. Charles J. David	Dartmouth
Dr. Richard L. Denton	Digby
Dr. David D. Forshner	Pugwash
Dr. Angus J. Gardner	Glace Bay
Dr. John G. Gatien	Halifax
Dr. Richard B. Goldbloom	Halifax
Dr. Alphonse J. Johnson	Halifax
Dr. John G. Kellett	Halifax
Dr. D. Grant Kirk	Antigonish
Dr. John R. LeMoine	Halifax
Dr. Roderick Landymore	Dartmouth
Dr. Christopher R. Loomer	Halifax
Dr. George R. Mahaney, Jr.	Halifax
Dr. Roger J. Michael	Halifax
Dr. Claire E. Murphy	Halifax
Dr. A. G. Patrick McDermott	Antigonish
Dr. George M. Novotny	Halifax
Dr. Wayne L. Phillips	Liverpool
Dr. R. Allan Purdy	Halifax
Dr. James L. Rafferty	Kentville
Dr. Robert W. Rice	Wolfville
Dr. Ian F. G. Robinson	Amherst
Dr. Gerald H. Ross	Wolfville
Dr. Peter D. Roy	Halifax
Dr. Narendra K. Sinha	Barrington Pas.
Dr. Peter L. Stevenson	Halifax
Dr. Frantisek Subrt	Halifax
Dr. Paula C. Tippett	Halifax
Dr. Morris E. Trager	Halifax
Dr. William D. R. Writer	Halifax
Dr. Tat Wah Wu	Sydney Mines
Dr. Gordon V. Young	Pictou
Dr. Ismail L. Zayid	Halifax