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JULY 1943

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*Editorial Board, Medical Society of Nova Scotia.*

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# Presidential Address

## HEALTH INSURANCE

W. ALAN CURRY

PRINCE BISMARCK of Germany in 1883, was the first to introduce a Health Insurance plan. Lloyd George in England during 1911, passed legislation to insure workers of a low income. The costs were partially borne by the employer and employee. Russia has complete State Medicine. Soviet physicians are divided into three groups, general practitioners, public health and specialists in the care of mothers and children. The main feature of Soviet Medicine is the concentration of medical practice in dispensaries, polyclinics and hospitals. Emphasis is laid on the problems of maternity and infant care, factory hygiene and control of venereal disease. Candidates for the study of medicine are selected by committees of workers and preference is given to their own classes. The student is paid a salary. The course is five years, but preliminary preparation is deficient and the demand for physicians is so great, that even one year of internship is often omitted. The State encourages scientific research by the expenditure of public funds. The Maxim Gorky Institute for Experimental Medicine includes a staff of six hundred scientists. A branch of this Institute was directed by the late Ivan Pavlov, one of the world's greatest physiologists.

At present there are forty-one European countries which have adopted Health Insurance. Of these thirty-three are compulsory and eight are voluntary. Within the past year or two, four South American countries, Argentine, Brazil, Columbia and Mexico have adopted compulsory health insurance. The majority of the schemes are only for those below a certain income, e.g. France limits the income to \$720, England to \$1200 and Germany to \$850. Some countries provide compensation for loss of time, others only supply free medical services. The majority only insure the workers. Others make provision for medical treatment of the dependents. Almost all these schemes are contributory by the insured. In Canada there are two provinces, British Columbia and Saskatchewan, which have health insurance bills passed by their legislatures. These bills were never put in force, owing to the lack of cooperation of the medical profession.

It is clearly evident that drastic changes in the practice of medicine are soon to take place in Canada, if the Federal Government implements the recommendations of the Special Committee on Social Security, which has been hearing briefs from the Canadian Medical Association and other interested groups during the past few months. Briefly the scheme of Health Insurance is divided into two sections (1) Preventive Medicine, which includes sanitation, contagious diseases, nutrition, cancer of which there are 12,000 deaths annually, venereal disease, public health laboratories, hospitals, dental care for children, physical fitness programmes for the young, (2) Curative Medicine is the branch that the majority of us are particularly interested in.

The recommendation of the Committee is to make Health Insurance universal in its application. All members of society are to be included, the indigent, those of modest incomes and their dependents, also the so-called rich. Every practitioner will be on a salary or fee for services. Special provision will be made to ensure adequate medical services in the rural areas. If

carried out, this means State Medicine. In order for the Federal Government to pass the bill, there would have to be an amendment to the British North American Act. The Government is loath to do this. Instead they plan to allow each province to decide whether Health Insurance is to apply to everybody or to have an income limit.

Under our present system of private practice, voluntary and provincial hospitals, the poor are well cared for in serious illnesses. The rich are well able to pay for their medical services. The hardship falls upon those in the middle income bracket. They are not eligible for the public wards. Private accommodation, with all the additional expense of X-ray, laboratory examinations, physician's and surgeon's fees are beyond their financial state. It often means that they put off entering hospital for treatment until they are in an advanced state of disease. There are certain isolated rural areas which under our present system have an inadequate medical service.

In my opinion Preventive Health Insurance should include every individual in the State. As regards Curative Medicine, insurance should include the indigent and those of low incomes with their dependents. I do not approve of those above a stated income bracket, say \$2,000 coming under it. If clients have sufficient means to take care of themselves, the State by interfering, exceeds its functions. It assumes a responsibility which should be borne by the individual. If everybody is included, the doctor will not have the same incentive to work hard and study. It is the competition of his colleagues in practice, which stimulates the physician to keep abreast of the times. State medicine will not attract as students, the keenest brains to enter it as a profession. The ambitious young men will be attracted to other fields where the reward of hard work will offer greater possibilities of financial award and independence.

The medical schools in the past have relied on voluntary and provincial hospitals for clinical material to teach the undergraduate students. Under Health Insurance there would be no public patients and each patient would be entitled to receive treatment from the physician of his choice. It would mean a very limited field for teaching. The standard of medical education might well be impaired, unless teaching privileges are preserved.

The financial cost of a complete Health Insurance has been estimated at \$250,000,000 yearly. The average annual contribution by each individual over sixteen years of age has been worked out at \$26.00. The balance of the costs would be borne by the Federal and Provincial Governments.

In conclusion I believe that Health Insurance will be a blessing to the indigent and those of modest incomes. Everybody should be included in Preventive Medicine. If Curative Medicine has a limitation of income, so that private practice may continue, I am of the opinion that it should receive the unanimous support of the medical profession.

# Pregnancy Complicating Pulmonary Tuberculosis\*

J. E. HILTZ, M.D.

Assistant Medical Superintendent  
Nova Scotia Sanatorium

THIS is not intended to be an exhaustive survey of the literature on this subject but, rather, a summary of some of the newer ideas concerning it coupled with a few observations regarding cases of pregnancy treated at the Nova Scotia Sanatorium.

Not so many years ago, every case of pulmonary tuberculosis that became pregnant was advised to have an abortion. It was felt that pregnancy in such a case spelled disaster. In all probability, this conclusion was reached by a superficial observation of all cases regardless of what time during or immediately following the pregnancy the tuberculosis was diagnosed. It is pretty well accepted that a woman who has unhealed tuberculosis but is unaware of its presence and who becomes pregnant, all the while living a normal life, looking after the household, taking considerable exercise in the fresh air, and even doing considerable hard work—such a woman will suffer from marked extension of her tuberculous disease in the vast majority of cases. However, the woman who knows that she has tuberculosis or discovers this shortly after she becomes pregnant will, in the majority of cases, do as well as a non-pregnant tuberculous patient with the same type of disease.

A number of years ago, a survey was carried out in the Sanatoria of the U. S. A. regarding this problem by Hill.<sup>2</sup> A large group of pregnant tuberculous women was studied. They were matched by a control group—each case with a counterpart as far as age, race, extent and type of disease were concerned.

It was found that of the women diagnosed as tuberculous *after* the birth of the baby, more were dead at the end of one and two years than in the comparable non-pregnant group. That their disease was probably advanced by the pregnancy due to the fact that they were not receiving any treatment for tuberculosis is suggested by the findings of the other two groups: (1) in the case of pregnant women who were diagnosed tuberculous during their pregnancy, there was the same mortality rate at one and two years as in the control group. (2) In the case of pregnant women who knew that they were tuberculous *before* they became pregnant and received proper care for both conditions, the outcome was in their favour. The mortality rate was actually higher in the control group. Other investigators have arrived at the same conclusions.<sup>3,4</sup> This, of course, is only if the patients are receiving proper care for both their tuberculosis and their pregnancy.

Is a therapeutic abortion ever warranted? We would say, "Yes, but seldom." We feel that it is never warranted in any patient over three months pregnant unless the obstetrical complication is such as would warrant termination of pregnancy even if the patient were not tuberculous. A therapeutic abortion may be indicated in a patient less than three months pregnant if her tuberculous disease is fairly extensive and of a recent type with considerable activity as evidenced by fever which does not respond to a trial period of

\*Read at the Meeting of the Valley Medical Society, June 2, 1943.

strict bed rest. It may also be indicated in a patient who is haemorrhaging from the lungs as this may, in itself, lead to extension of the tuberculous process.

In the case of active disease which is seen to be responding to bed rest, the pregnancy may be allowed to proceed to term. Wherever possible, collapse treatment for the lung should be initiated as soon in pregnancy as the patient's condition will permit. We hesitate to initiate pneumothorax treatment in any febrile case. The same applies, to a less extent to phrenic paralysis, and to a greater extent to major surgery such as thoracoplasty. The pregnancy will not be affected adversely by the collapse measures employed and the tuberculous disease will be controlled thereby.

On a number of occasions, it will be necessary to perform Caesarean section. Generally speaking, the indications for this will be a patient with a considerably reduced vital capacity, one who is running active disease, or has had a recent haemoptysis or any one in whom the strain of labour is considered to be too great; also any case with some obstetrical complication such as a moderately contracted pelvis which would not be quite sufficient to warrant the operation in a non-tuberculous patient. Most multiparae may proceed to a normal termination.

Following the birth of the baby is the danger period for the mother. Post-partum blood loss should be reduced to a minimum in order not to lower her resistance. She should not be allowed to nurse the baby for two reasons: the milk of tuberculous mothers frequently contains tubercle bacilli and so the baby may become infected; the strain of lactation should not be imposed upon the mother. Oral administration of stilboestrol on the day of delivery and subsequently will inhibit the engorgement of the breasts and make for a more comfortable puerperium. This preparation, of course, may be given hypodermically as well.

Following the birth of the baby, too, the mother should be maintained at strict and absolute bed rest for a month and then may be allowed to gradually return to the degree of activity permitted before the birth or that indicated by the extent of the disease present.

It has been suggested—and rightly so—that the improvement noted in the lung condition during the last few months of pregnancy may be due to the increased elevation of the diaphragms and consequent compression and relaxation of lung tissue. This may also account for the frequent extension of disease noted following delivery in those cases unaware of their tuberculosis or improperly treated. The sudden descent of the diaphragms causes considerable strain to be thrown upon healed or healing disease. Therefore, in all cases of tuberculosis, after delivery, a tight abdominal binder and a ten to twenty pound sand bag should be applied to the abdomen in order to prevent the diaphragms from returning to their normal position too suddenly.

Sterilization may have to be considered in many of these cases. One pregnancy may be borne all right, in many instances two, but an increasing number of patients will break down after a third or more. Particularly is this true where the pregnancies occur close together.

Since 1935 we have followed nine cases to term at the Sanatorium. There was one death in a woman, 22 years of age, admitted with advanced disease and 6½ months pregnant. She ran a febrile and haemorrhagic course throughout and died the day after her normal baby was born. The other eight women are still alive. We did not lose a baby. The babies, of course, were sent to

a general hospital immediately after birth. They all left the sanatorium within an hour or less of the time of birth. None of the babies died during the stay in the local hospitals but one did die some weeks after returning home. The cause of death was given by the family physician as cerebrospinal meningitis. Five of the cases were delivered by Caesarean section and four delivered normally.

The following are very brief reports concerning two typical cases:

1. Mrs. N. M., age 33, nulliparous. She had been a patient at the Nova Scotia Sanatorium from April 7, 1934 to April 27, 1935. At that time, there was a cavity within the left lung which was treated by artificial pneumothorax and phrenic evulsion with satisfactory results. Pneumothorax treatment was completed in May, 1936, and the lung permitted to re-expand. She was readmitted to the sanatorium on March 21, 1938, with reactivation of disease, there being a cavity  $5 \times 3\frac{1}{2}$  cm. present now within the middle portion of the left lung. The left diaphragm was seen to be very high and immobile due to the previous phrenic evulsion. The right lung was free from disease. At our staff conference, the case was considered to be suitable for thoracoplasty.

The patient, at that time, was three months pregnant. However, a three stage thoracoplasty was completed on April 29, 1938, a total of eight ribs being removed on the left side.

Due to the patient's diminished vital capacity, plus the fact that she was nulliparous, it was decided that the baby should be delivered by Caesarean section. This was performed on September 1, 1938. Mother and child are both living and well to-day.

2. Mrs. V. C., age 19, nulliparous. She was admitted to the Sanatorium on October 17, 1938, with a partly healed lesion within the right upper lobe which contained a cavity  $3\frac{1}{2} \times 3$  cm. There was a small amount of disease at the left apex. The case was inoperable for pneumothorax treatment due to the presence of pleural adhesions. At our staff conference, she was passed for a thoracoplasty on the right side. However, as she was eight months pregnant at the time, it was decided to postpone chest surgery until after delivery. On November 9, 1938, she was delivered normally of a healthy child, without any extension occurring in the tuberculous disease of the lungs. On January 27, 1939, a two stage thoracoplasty was completed, a total of six ribs being removed. Mother and child are both well to-day, although the mother occasionally has a few tubercle bacilli in the sputum.

To summarize: A tuberculous pregnant woman should not have either of her conditions treated separately; both are important; both deserve the best of care. There could be complete co-operation between the obstetrician and the tuberculosis internist. These cases should be treated in an institution where both conditions can be supervised properly. If given adequate treatment, the patient will do as well or better than if she were not pregnant.

A physician once said of a patient, "We shall treat his diabetes after his pneumonia clears up." Of course, in all probability, the pneumonia did not clear up. It is equally bad medical practice to leave the treatment of the tuberculosis until after the pregnancy has been terminated.

#### BIBLIOGRAPHY

1. Goldberg: "Clinical Tuberculosis": F. A. Davis Company, 2nd Revised Edition, J3.
2. Hill, Alice M.: *Am. Rev. Tuberc.*: 16, August, 1927. 17, February, 1928.
3. Ornstein: Goldberg's "Clinical Tuberculosis": F. A. Davis Company, 2nd Revised Edition, J3.
4. Skillen & Bogen: *J.A.M.A.*, 111, p. 1153: September 24, 1938.
5. Abarbanel et al: *J.A.M.A.*, 121, p. 1126: April 3, 1943.

# Quarantine Regulations for Communicable Diseases—Terminal Disinfection\*

J. S. ROBERTSON, M.D., D.P.H.

Divisional Medical Health Officer  
Yarmouth, N. S.

Mr. Chairman, Ladies and Gentlemen:

Under this title I propose discussing briefly quarantine, isolation and disinfection as it should be practised in communicable disease under modern public health practice. These subjects should be of interest to all practitioners in Nova Scotia where the vast majority do general practice and are as a result constantly finding situations in communicable diseases which they must handle adequately if the spread of infection is to be stopped. The specialists also should be aware of their values—particularly N. & T. men who frequently see suspicious cases which should be under sanitary supervision.

In April, 1941, new regulations were brought out, in order to bring our regulations more in line with modern sanitary practice. It is being realized as our knowledge of the modes of spread of communicable disease is increased that quarantine *per se* will not control disease, none the less it is an important factor in such control, unless we take into account every factor in disease control we are not apt to get results.

Although the terms *isolation* and *quarantine* are often used interchangeably, *quarantine* should be used to refer to the limitation of movement of persons exposed to the disease, *isolation* should refer to the separation of the sick person from the well. This distinction should be made clear for the periods of detention usually differ markedly, for example in diphtheria the quarantine period for contacts is seven (7) days, while the isolation period for the patient is a minimum of twenty-one (21) days.

Of late years the value of quarantine and isolation has been criticized, chiefly because epidemics have continued to arise after years of such control methods. However it may well be asked—is this not because of inadequate enforcement of quarantine? Certainly there are a few diseases in which quarantine fails because of the fact that the disease is infectious before diagnosis is possible, for example measles, which is infectious several days before the characteristic rash appears. However, the greater number of diseases are not particularly infectious at the time diagnosis is possible, in these diseases the failure of control appears to be the failure on the part of practitioners to notify the proper authorities regarding the existence of the disease, thus allowing the disease to become widespread in a community. When this occurs there is a great outcry for quarantine measures, the disease continues to spread in spite of this—and quarantine is again regarded as a failure. If practitioners would accept their responsibilities toward the general public as well as toward the single patient I feel sure that fewer cases of communicable disease would be the result. As with bad news it is surprising how news of a laxity towards quarantine becomes known, and a particular doctor called if communicable

\*Paper presented at the 90th Annual Meeting of The Medical Society of Nova Scotia, Kentville, Nova Scotia, July 7, 1943.



disease is suspected—the family apparently knowing that “Dr. . . . . . doesn’t quarantine for measles, etc.” Individualism is all right in its own place, but I do not believe that a physician should for his own gain allow innocent children to be exposed to the dangers of communicable disease, he should be broad-minded enough to accept other ideas than his own when the health of others is concerned—I do not believe that it has helped any man’s practice to set up quarantine rules of his own—he may be popular with the family in which the initial case occurs, but the neighbors are usually not backward in expressing their views of the procedure.

Now just what are the present day regulations regarding Communicable Disease in Nova Scotia? These may be briefly mentioned under the following headings—Notification, Notifiable Diseases, Modified and Absolute Quarantine, Duration of Isolation and Quarantine, School Attendance.

*Notification*—The physician attending a case if diagnosed or suspected of being one of the notifiable diseases other than tuberculosis, venereal or skin disease shall notify the Medical Health Officer within twenty-four (24) hours. This report may be made by telephone and shall include name, age and address of patient together with the name of the disease. It is then incumbent upon the Medical Health Officer so notified to see that a placard is placed on the premises, either by the householder, the Medical Health Officer or his agent, usually a sanitary inspector. It is surely not any great hardship to pick up a telephone after diagnosing a case and give the information to the Medical Health Officer. From then on the maintenance of quarantine is the function of the local Board of Health through its executive, the Medical Health Officer. No criticism can fall on the practitioner for carrying out his lawful duty. Once the case has been diagnosed, it is the duty of the practitioner to secure the isolation of the patient in order to protect the quarantined family as much as possible—this usually means placing the patient in a room by himself as far away from the rest of the family as possible—unfortunately in a small home proper isolation is not easy to attain.

After the notification has been made to the Medical Health Officer he must as stated before see that a proper placard is placed, that quarantine is maintained and that arrangements for feeding the quarantined family are carried out.

The placard should be a yellow card, not less than twelve inches (12”) square—it should contain (1) name of the disease, (2) period of isolation or quarantine, (3) penalty for its removal without the permission of the Health Officer.

*The Notifiable Diseases* have been divided into two (2) groups, A & B. Both groups must be reported to the Medical Health Officer; however, only Group A comes under the standard quarantine procedure—only at the discretion of the Medical Health Officer are diseases in Group B to be quarantined. Group A contains the common communicable diseases, including measles, whooping cough, chickenpox and mumps—incidentally the number of man hours lost by men in the Army in Nova Scotia in the last year or so from mumps would I feel be almost enough to capture Berlin.

Isolation of patients with diseases in Group A must be complete—that is only the physician and nursing attendants should visit the room; dishes, linen, etc., should be for use only of the patient.

*Carriers of Diseases* in Group A should be isolated until the danger of infection to others is non-existent, especially if the patient is not careful and co-operative. Careful laboratory work is required in order to diagnose carriers—no case of diphtheria, scarlet fever or typhoid fever should be released until negative laboratory reports are received. The Medical Health Officer should be insistent on this point.

*Quarantine of Contacts*—This may be either absolute or modified—this is the section of the regulations which cause the greatest trouble, due I believe to faulty interpretation by the physician. In certain diseases such as cholera (Asiatic), smallpox, plague, typhus fever and chickenpox until diagnosis is certain the quarantine must be absolute, that is even the breadwinner is not to be allowed off the premises. I feel quite sure that no physician would advocate looser quarantine standards for the control of smallpox—then why not use the same thinking in the control of whooping cough—many more children die from whooping cough than from smallpox in Nova Scotia—why should not the same rigid control methods be used—at least until our pre-school children are all immunized. If we accept the fact that absolute quarantine is an important factor in the control of smallpox and Asiatic cholera then we should not be in too much of a hurry to abandon quarantine as a control measure in other diseases.

*Modified Quarantine*—Unless the principle behind this is understood and carried out—the procedure results in the spreading of disease due to carriers, unrecognized cases, etc. The idea behind modified quarantine is that in any household in which there are certain types of communicable disease such as diphtheria, mumps and whooping cough, some members of the family will be immune because of having had the disease, or having been immunized or possess a degree of immunity because of age, etc. These persons may be released after certain precautions are taken, at the discretion of the Medical Health Officer. For example in diphtheria if the breadwinner has had the disease, he may be released after negative nose and throat swabs have been reported, in a family with whooping cough the grown up members of the family may be released—remembering always however that certain grown ups may have whooping cough, the symptoms being those of a severe bronchitis—such persons should be held in isolation. Such releases as have been described always presuppose that the case is *strictly isolated*—this point cannot be over-emphasized. Furthermore the house must be placarded. Immune children and others from such homes should if at all possible be sent to live in other homes after they have been shown to be non-carriers—for it is seldom that we feel that isolation of the patient is complete from the rest of the family during the infectious state of the disease.

*Duration of Isolation and Quarantine*—The time for isolation of the patient is set down in the regulations—certain modifications have occurred, for example the isolation time for scarlet fever has been reduced from 35 to 28 days. Furthermore if laboratory control is utilized the time of release in certain diseases can be shortened—for example in diphtheria with negative swabs, a case may be released in ten (10) days, otherwise a minimum of twenty-one (21) days is set down. There has been a tendency to allow diphtheria cases out in ten (10) days without any swabs being taken—there is no justification for this—the regulations are quite plain on this point—it is surely no great

hardship for a physician to take swabs on a convalescent diphtheria patient and thus make sure the public is being protected as far as possible from this serious illness. In this connection also there is a tendency for the attending physician to tell the household about time of release, particularly speaking of release earlier than is lawful—it should be realized that quarantine or isolation cannot be abandoned lawfully without the consent of the Medical Health Officer or the local Board of Health—quarantine is instituted in the public interest and should only be lifted in the public interest. It is realized that quarantine often results in hardships for the non-sick members of a household. With proper co-operation of the physician many members can often be released to allow their income to continue without any public danger. In certain cases, however, the entire family must remain in quarantine and it is my belief that some arrangement should be made from public funds to compensate these—through no fault of their own their liberty and means of earning is being curtailed for the public benefit—possibly in the hoped for Utopian days of Health Insurance some arrangement will be possible.

*Quarantine Periods for Contacts* are set down to cover the known incubation periods of communicable diseases—it always being presupposed that there is no further contact between the patient and the contacts after isolation of the patient is carried out. Again, if proper isolation is not instituted, the contacts may develop the disease after release with subsequent public danger—the attending physician is again asked to note that the instituting of proper isolation of the patient is his function.

*School Attendance*—Except for certain exceptions to be noted later no child from a quarantined home shall attend school without a certificate from the Medical Health Officer or Board of Health—stating that infection no longer exists and that proper disinfection has been carried out.

The exceptions are (1) in cases of chickenpox, German measles, mumps, measles and whooping cough—here if the Medical Health Officer is satisfied with the isolation of the patient and that the persons concerned have had the disease—he may issue a certificate for school attendance without having them change their residence. (2) Certain persons who are allowed to change their residence after quarantine is instituted, may with the written permission of the Medical Health Officer be allowed to attend school after they have been out of the home for the period of quarantine—that is after normal incubation period of the disease has elapsed.

Again it should be made clear that the Medical Health Officer must give the written permission—this is not a function of the attending physician. In giving certificates for school attendance the question of carriers must always be remembered—no certificate should be given in diphtheria cases without previous negative swabs—similarly, in scarlet fever no child with running ears should be allowed to attend school until the discharge has been shown by swabs to be non-infectious.

*Disinfection*—Fumigation was formerly considered the best form of disinfection for communicable disease—now fumigation is known to be ineffective—its chief use now being the destruction of vermin. Previously large amounts of money were spent yearly in carrying out this procedure, this change in itself being a considerable saving to the municipalities.

*Concurrent Disinfection* by which is meant the destroying of all infectious discharges at once by means of burning the discharges, liberal use of soap and water, boiling bed clothes and so on is one of the most important preventative measures in the prevention of spread of communicable diseases. Strict instructions should be left by the attending physician regarding this procedure—no infected material should be allowed out of the sickroom to come into contact with well persons. The attendant should be scrupulous in the careful washing of hands, both her own and the patients. Excreta from the patient should be treated with such chemicals as Milk of Lime or carbolic acid or equivalents—this is particularly important when water carrier systems are not available.

*Terminal Disinfection*—This takes the place of the old fumigation—if concurrent disinfection has been well carried out, the procedure is almost unnecessary. This procedure in the regulations must be carried out in small-pox, scarlet fever, tuberculosis and such other diseases as may be required by the Medical Health Officer. In other diseases the Medical Health Officer may, if he thinks concurrent disinfection has been well carried out merely order discontinuance of isolation and quarantine.

In the process as outlined in the regulations, those things of small value should be burned, bed clothes, etc., should be boiled, all woodwork and bed to be washed thoroughly with soap and water, a solution of some antiseptic used to soak into cracks, etc., the room left open to sun and air for a day or so, then if necessary redecoration carried out.

Incidentally, in cases of death from communicable disease the Medical Health Officer may order the body placed in a coffin and the cover closed permanently—further he may order the funeral to be private. It is felt that except in the mildest of the communicable diseases that these procedures are best carried out for the public protection.

It will be noted in all the foregoing regulations that certain duties are obligatory on the householder, others on the attending physician and others on the Medical Health Officer. The modern tendency is to make less rigorous the quarantine, nevertheless this cannot be carried too far, even though quarantine and isolation has failed to curb epidemics by themselves, we feel that they play a part in control. If each quarantine incident prevents even one further case of infectious disease, it has been well worth while.

It is to be regretted that many general practitioners fail to report cases of communicable disease, thus taking to themselves the function of the Boards of Health—failure to report and subsequently quarantine the first household may result in widespread grief in a community.

Quarantine is only one of the methods of protection we have against communicable diseases—it is not perfect—yet we are not prepared to lose its protection—partial only though this may be. We would ask that you do all in your power to see that when necessary, quarantine be enforced—the general public will be with you although some misguided individuals may feel aggrieved.

# Report of the Refresher Course Committee For the Year 1942-43

THE Committee met at the beginning of the year and decided that with the war still on and most of the doctors very busy, it would not be wise to hold the regular Refresher Course. At the suggestion, however, of Dr. Eric Macdonald of Dominion, Cape Breton, it was decided to offer speakers and clinicians to the branch societies. The Faculty of Medicine was accordingly circularized asking for contributions and the following responded.

- DR. W. ALAN CURRY - Talks, illustrated by lantern slides on
1. Experience with frost bite and amputation.
  2. Intestinal obstruction.
  3. Cancer of the large bowel.
  4. Cancer of the stomach.
  5. Cancer of the breast.
- DR. A. F. MILLER - - Talk with exhibits of a number of interesting X-ray films.
- DR. H. G. GRANT - - Talk on the practical side of preventive medicine.
- DR. H. B. ATLEE - - Talk on Vaginal Hysterectomy; Posterior Positions and their handling; Hormone Treatment of Female Glandular Irregularities.
- DR. ARTHUR L. MURPHY Talk on either of these subjects:
1. The Post-traumatic Headache: Its differential diagnosis and treatment (illustrated by diagrams and X-rays).
  2. Internal Fixation of Fractures: Its application in the light of recent surgical and physiological advances (Illustrated by diagrams and X-rays).
- DR. R. O. JONES - - Talk on—  
Insulin and Convulsive Shock Therapy in the Psychosis; Neurosyphilis as a Problem in General Practice; Diagnosis and Treatment of Anxiety-Neurosis.
- DR. N. H. GOSSE - - Talk on—  
Peptic Ulcer or Some Conditions of the Anus and Rectum. If scheme is sufficiently extensive, and involved meeting in a hospital, the former as a paper and the latter or some other thing as a clinic.
- DR. K. A. MACKENZIE - Talk on—On the Diagnosis of Brain Tumours.
- DR. M. K. McPHAIL - Talk on—The Sulphonamides.

- DR. R. W. M. MACKAY - Talk on—  
Treatment of Mental Diseases, particularly those conditions where something constructive can be done, such as, thermal therapy in general paresis, and insulin therapy in dementia praecox.
- DR. C. B. WELD - - Paper on—  
Blood transfusions and transfusion materials; or a moving picture film, The Control of Small Blood Vessels.
- DR. P. WEATHERBE - - Lecture or clinic on—The Acute Abdomen in Children.
- DR. E. G. YOUNG - - Paper on—Modern Aspects of Nutrition.
- DR. J. V. GRAHAM - - The value of the knowledge of anatomy in the work of the general practitioner, with examples.
- DR. NORMAN S. SKINNER Asthma: Coronary Artery Disease.
- DR. GEORGE F. SKINNER Three things present themselves to my mind  
(letter dated immediately. First, a week ago the students were  
October 8, 1942) very much interested in a series of X-rays that I gathered covering the whole subject of hip injuries, from childhood to old age, and stressing "aseptic necrosis" starting with a series of cases of Perthes' disease through slipped epiphysis, dislocated hips of middle age and finally necks and trochanters. If you want to list this as hip injuries, I think we might be able to gather enough lantern slides for a fair demonstration. This, of course, would be such a broad subject that it would be a superficial survey rather than a statistical or technical review. Secondly, the group here last winter were very much interested in a review of the treatment of varicose veins up to present-day status. This, of course, would be listed as the "treatment of varicose veins." Thirdly and finally, if you thought such groups would be at all interested, we might discuss any subject on thoracic surgery. Possibly empyema might have some appeal, but I find that other thoracic subjects have only the appeal of novelty to a general group. Personally, I would like to try working up the first subject.
- DR. T. B. ACKER - - Papers on—  
1. Surgery in Infantile Paralysis.  
2. Recent concepts in functional disorders of the feet.
- DR. J. C. ACKER - - Paper on—  
Advances in the treatment of congenital club feet, dislocated hips and torticollis.

DR. GEORGE M. WHITE - Papers on—

1. Normal Delivery.
2. Posterior Positions.
3. Uterine Prolapse.
4. Heart Disease in Pregnancy.

The above list was then sent to the Branch Societies asking them to make a choice if they wished any of the speakers to address their meetings. From November, 1942 to May, 1943, there were 11 speakers sent out to the several Branch Societies as follows:—

Dr. M. K. McPhail, Dr. A. L. Murphy, Dr. W. Alan Curry and Dr. R. O. Jones at meetings of the Western Nova Scotia Medical Society; Dr. R. O. Jones, Dr. H. B. Atlee and Dr. W. Alan Curry at meetings of the Pictou County Medical Society; Dr. K. A. MacKenzie, Dr. H. B. Atlee, Dr. W. Alan Curry, Dr. A. L. Murphy and Dr. P. Weatherbe at meetings of the Valley Medical Society; Dr. K. A. MacKenzie at a meeting of the Cumberland Medical Society; Dr. H. B. Atlee at a meeting of the Colchester-East Hants Medical Society; Dr. H. K. MacDonald, Dr. W. Alan Curry, Dr. A. L. Murphy, Dr. Norman S. Skinner and Dr. C. E. Kinley at meetings of the Cape Breton Medical Society and Dr. George F. Skinner and Dr. Norman S. Skinner at meetings of the Halifax Medical Society.

It is the unanimous opinion of the Committee that this work was well worth while and should be continued. Several letters of appreciation were received from Branch Societies.

At the last meeting of the Committee it was decided to give a Refresher Course in October for the benefit of the physicians of the Maritimes and Newfoundland to include members of the armed forces stationed here.

Respectfully submitted

J. V. GRAHAM, Chairman

# REGISTRATION

90th ANNUAL MEETING

THE MEDICAL SOCIETY OF NOVA SCOTIA

JULY 7th AND 8th, 1943

"CORNWALLIS INN," KENTVILLE, N. S.

- Dr. D. F. McInnis, Shubenacadie  
Dr. D. Drury, Amherst  
Dr. H. E. Kelley, Middleton  
Dr. J. P. McGrath, Kentville  
Dr. J. E. Hiltz, Kentville  
Dr. A. F. Miller, Kentville  
Dr. C. L. MacMillan, Baddeck  
Dr. W. L. Muir, Halifax  
Dr. H. G. Grant, Halifax  
Dr. H. S. Smith, Caledonia  
Dr. Ralph B. Cox, Collinsville, Conn.  
Dr. P. E. Belliveau, Meteghan  
Dr. R. S. Ideson, Kentville  
Dr. J. J. Quinlan, Kentville  
Dr. V. F. Connor, Digby  
Dr. C. B. Crummey, Trenton  
Dr. H. W. Schwartz, Halifax  
Dr. Eric W. Macdonald, Reserve  
Dr. J. R. Macneil, Glace Bay  
Dr. F. L. Hill, Parrsboro  
Dr. J. W. Smith, Liverpool  
Dr. H. Robertson, Halifax  
Dr. Ross Millar, Ottawa  
Dr. J. R. Corston, Halifax  
Dr. A. McD. Morton, Halifax  
Dr. D. Murray, Tatamagouche  
Dr. J. Stewart Murray, River John  
Dr. G. A. Dunn, Pictou  
Dr. S. D. Dunn, Stellarton  
Dr. D. W. N. Zwickler, Chester  
Dr. C. S. Henderson, Parrsboro  
Dr. S. G. MacKenzie, Truro  
Dr. D. K. Murray, Liverpool  
Dr. Allan R. Morton, Halifax  
Major K. J. R. Wightman, Sussex, N. B.  
Dr. J. J. MacRitchie, Halifax  
Dr. D. M. MacRae, Halifax  
Dr. J. B. Reid, Truro  
Dr. D. B. Wilson, Toronto  
Dr. G. D. W. Cameron, Ottawa  
Dr. C. H. Best, Toronto  
Dr. V. D. Schaffner, Kentville  
Dr. A. L. Sutherland, Sydney  
Dr. L. M. Morton, Yarmouth  
Dr. W. F. MacKinnon, Antigonish  
Dr. G. Watson Sodero, Sydney  
Dr. T. C. Routley, Toronto  
Dr. D. S. Lewis, Montreal  
Dr. H. K. MacDonald, Halifax  
Dr. R. A. MacLellan, Rawdon Gold Mines  
Dr. C. F. Blackler, Ottawa  
Dr. G. Graham Simms, Pictou  
Dr. Donald S. Robb, Kentville  
Dr. B. S. Bishop, Kentville  
Dr. M. R. Elliott, Wolfville  
Dr. W. Alan Curry, Halifax  
Dr. Roscoe R. Graham, Toronto  
Dr. George H. Muppy, Halifax  
Dr. Charles S. Morton, Halifax  
Dr. A. E. Blackett, New Glasgow  
Dr. J. M. Stewart, Halifax  
Dr. Charles J. W. Beckwith, Sydney  
Dr. J. S. Robertson, Yarmouth  
Lt.-Col. T. A. Lebbetter, Ottawa  
Dr. R. A. Moreash, Berwick  
Dr. Judson V. Graham, Halifax  
W/C. C. B. Stewart, Halifax  
Dr. W. H. Eagar, Wolfville  
Dr. K. A. MacKenzie, Halifax  
Dr. S. Worobetz, Regina  
Dr. W. G. Reive, Aldershot  
Dr. J. A. Ross, Aldershot Hospital  
Dr. Frank G. Mack, Halifax  
Dr. W. K. House, Halifax  
Dr. Arthur L. Murphy, Halifax  
Dr. J. S. Morrison, Halifax  
Dr. F. D. Charman, Truro  
Dr. E. P. Brison, Halifax  
Dr. L. A. Pennington-Collier, Halifax  
Dr. Laverne E. Cogswell, Berwick  
Dr. H. B. Atlee, Halifax  
Dr. Eldon L. Eagles, Windsor  
Dr. V. H. T. Parker, Stellarton  
Dr. G. B. Wiswell, Halifax  
Dr. Henry B. Ross, Halifax  
Dr. A. E. Murray, Halifax  
Lt. Robert M. Levine, Montreal



- Lt. F. R. MacRae, Montreal  
 Captain E. H. Brotman, Winnipeg  
 Lt. D. B. Law, Ottawa  
 Capt. M. Lerner, Winnipeg  
 Dr. H. W. Kirkpatrick, Halifax  
 Dr. B. W. Skinner, Mahone Bay  
 Hon. F. R. Davis, Bridgewater  
 Lt.-Col. R. G. Reid, Montreal  
 Dr. R. S. Shlossberg, New Glasgow  
 Major M. Johnson, Halifax  
 Capt. T. S. Wilson, 6th Fd. Amb., R.C.A.M.C.  
 Major J. C. McKellar, Toronto  
 Dr. K. P. Hayes, Halifax  
 Dr. W. T. McKeough, Sydney Mines  
 Dr. B. Laski, Toronto  
 Dr. Thomas A. Kirkpatrick, Kentville  
 Dr. H. A. Foley, Canning  
 Surg. Lt. Cmdr. J. Wallace Graham, Halifax  
 Dr. K. G. McKenzie, Toronto  
 Dr. G. V. Burton, Yarmouth  
 Dr. Wallace M. Roy, Halifax  
 Dr. Chas. E. Vaughan, R.C.N., Halifax  
 Dr. J. C. Wickwire, Liverpool  
 Dr. G. K. Smith, Hantsport  
 Dr. Basil K. Coady, R.C.N.V.R., Halifax  
 Dr. A. Hines, Cheverie  
 Dr. J. W. Merritt, Halifax  
 Dr. O. B. Keddy, Windsor  
 F/L. J. A. Webster, R.C.A.F., Greenwood
- Dr. A. R. Chisholm, Kentville  
 Major Charles Manly, Winnipeg  
 Captain Ronald Place, R.C.A.M.C., Montreal  
 Dr. Hugh MacKinnon, Halifax  
 Dr. J. H. Buntain, Kentville  
 Dr. G. W. Turner, Windsor  
 Lt.-Col. R. H. Sutherland, Sydney  
 Dr. S. T. Laufer, Halifax  
 F/L. G. D. Donaldson, Sydney  
 Dr. L. A. Rosere, Newport  
 Dr. Elizabeth C. Morris Eaton, Amherst  
 Dr. D. M. Cochrane, River Hebert  
 Dr. M. J. Wardrope, Springhill  
 Dr. M. R. Macdonald, Sydney  
 Dr. H. E. Killam, Kinsman's Corner  
 Dr. B. W. Stevens, Toronto  
 Dr. Ralph A. Young, Wolfville  
 Mrs. (Dr.) Ralph A. Young, Wolfville  
 Dr. A. L. Anderson, Wolfville  
 Dr. S. E. Bishop, Kentville  
 Dr. S. Marcus, Bridgewater  
 Lt. J. R. Feindel, Bridgewater  
 Col. G. Ronald Forbes, R.C.A.M.C., Halifax  
 Dr. J. H. L. Simpson, Springhill  
 Dr. T. B. Acker, Halifax  
 Dr. J. C. Acker, Halifax  
 Dr. Bowman Crowell, Chicago  
 Dr. M. Jacobson

## The Meyers Memorial

The Canadian Medical Association receives the sum of \$100.00 a year from the estate of the late Doctor Campbell D. Meyers of Toronto to provide an honorarium known as the Meyers Memorial.

The award is made in accordance with the instructions of the donor, which are:

- (1) That the award shall be made “. . . to such member or guest of the Canadian or of one of the Provincial Medical Associations as shall write and read at the annual meeting of any of the said Associations the best thesis or dissertation . . .”
- (2) That the subject shall be “. . . the study and treatment of those functional neuroses which, if untreated, or not treated sufficiently early might probably terminate in insanity . . .”  
“. . . it is impossible to classify definitely the type of diseases referred to above. I desire however to refer to those Functional Neuroses in which the psychological symptoms form the essential part of the syndrome, and to that type of Neurosis which develops in late adolescent or in adult life in a patient of previous good mental and nervous history, especially such neurosis as has its etiology in emotional overstrain caused by excessive grief, worry and allied conditions . . .”  
“I desire to exclude from this thesis the study of Mental Defectives, paranoia and similar conditions of mental disease due to hereditary or organic states . . .”
- (3) That the award shall be made “. . . by a Committee consisting of the President, a physician and a neurologist . . .”

Anyone wishing to submit a thesis is advised to confer in advance with the Chairman of the Meyers Memorial Committee (through the office of the Canadian Medical Association) in order to make sure that his thesis will come within the terms of the award.

The thesis must be in the hands of the Chairman of the Meyers Memorial Committee on or before May 31st if it is to be considered for the award of that year and should be forwarded to him at 184 College Street, Toronto. Any thesis received after May 31st will be considered as being submitted for the following year.

## Society Meetings

### WESTERN NOVA SCOTIA MEDICAL SOCIETY

The Annual Meeting of the Western Nova Scotia Medical Society was held on June 3rd at Green Tree Inn, Hebron, at 6.30 p.m.

Following a delightful luncheon we were favored with two interesting and instructive papers, both ably presented.

Dr. Robt. Jones, of Halifax, gave his experiences with the Electric Shock treatment in Psychoses and Prof. M. K. McPhail brought us up to date in sulfa drug therapy. We are indeed indebted to the Dalhousie Refresher Course Committee for supplying these speakers.

Election of officers resulted in the following being chosen:

President—Dr. J. S. Robertson, Yarmouth.

Vice-Presidents—Drs. O'Brien, Hawkins and Ramsay.

Secretary-Treasurer—Dr. D. F. Macdonald, Yarmouth.

### WRITING OF PRESCRIPTIONS FOR LIQUOR

A letter has been received from Mr. A. S. Mahon, Chief Commissioner of the Nova Scotia Liquor Commission, complaining about the recent increase in the writing of prescriptions for liquor by members of The Medical Society of Nova Scotia. Together with this letter was a statement showing the number of prescriptions filled by the individual shops of the Liquor Commission from December 1, 1942 to May 26, 1943, a period of roughly six months. All kinds of liquor were prescribed, varying from beer, stout and wine to whisky, brandy, rum and gin. Most of the members mentioned wrote one or two prescriptions in that period; a few wrote over twenty, some over thirty, and one as many as sixty-eight. The Executive regrets that it was necessary for the Chairman of the Liquor Commission to complain about the number of prescriptions written by our members and we feel that a great number of these prescriptions were not needed. We ask that from now on all members refrain from the writing of non-essential prescriptions for alcohol. Your co-operation will make Government intervention unnecessary.

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### ANY PHYSICIAN MAY EXHIBIT "WHEN BOBBY GOES TO SCHOOL" TO THE PUBLIC

Under the rules laid down by the American Academy of Pediatrics, their educational-to-the public film, "When Bobby Goes to School," may be exhibited to the public by any licensed physician in the United States.

All that is required is that he obtain the endorsement by any officer of his county medical society. Endorsement blanks for this purpose may be obtained on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film in advance of public showings in the community.

"When Bobby Goes to School" is a 16-mm. sound film, free from advertising, dealing with the health appraisal of the school child, and may be borrowed without charge or obligation on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

## Personal Interest Notes

COLONEL G. R. FORBES, R.C.A.M.C., formerly of Kentville, has vacated the appointment of district medical officer, Military District No. 6, on being appointed to the command of No. 9 General Hospital, R.C.A.M.C.

The marriage took place at Halifax on July 6th, at the home of Mr. and Mrs. C. Russell Johnson, 351 Quinpool Road, of their only daughter, Mary Russell and Lieutenant John Francis Lydiard Woodbury, R.C.A.M.C., (Dal., Jan. 5, 1943), son of Dr. and Mrs. F. V. Woodbury of Halifax. Following a trip in the Province, Lieutenant and Mrs. Woodbury will reside in Kingston, Ontario, for the present.

The marriage took place in England on March 13th of Lieutenant (Nursing Sister) Katherine L. MacDonald, No. 7 Canadian General Hospital, and Captain Allan Donald MacDonald, formerly of the 22nd Field Ambulance, now of No. 1 Royal Canadian Army Service Corps Reinforcement Unit. Mrs. MacDonald is the youngest daughter of the late Mr. and Mrs. D. D. MacDonald, Antigonish, a graduate of St. Francis Xavier University and of the Halifax Infirmary School of Nursing. Captain MacDonald is the eldest son of A. A. MacDonald and the late Mrs. MacDonald, Waverley Road, Dartmouth. He is a graduate of Guy's Hospital, London, and before joining for active service practised his profession in New Waterford, N. S.

Dr. S. E. Bishop, son of Dr. and Mrs. B. S. Bishop of Kentville, has left for Toronto to join the R.C.A.F. Dr. Bishop graduated from Queen's in 1939, and spent the following year on the staff of the Ottawa General Hospital and Grace Maternity Hospital, Ottawa. Before entering into private practice he was on the staff of the Lakeview Hospital, Chicago, and Toronto General Hospital.

The BULLETIN extends congratulations to Dr. and Mrs. Robert O. Jones of Halifax on the birth of a daughter on May 18th, and to Dr. and Mrs. Austin A. Macdonald (Marie Grant, R.N.) of Neil's Harbour on the birth of a son, Brian Lee, on July 13th.

The Blood Donor Clinic opened at Yarmouth on June 8th, under the direction of Dr. Margaret Gosse, assisted by Dr. L. M. Morton, Dr. W. C. O'Brien, Dr. G. W. T. Farish and Dr. D. F. Macdonald. Forty-one active service men from the Canadian Basic Training Centre in Yarmouth were the first donors. The following week members of the Yarmouth Rotary Club and additional service men were donors. The Clinic now operates each Tuesday and Friday.

## Obituary

THE death occurred in North Sydney on July 10th of Doctor Alexander Kerr Roy, aged sixty-one, following a short illness. Doctor Roy was born August 2, 1881, at Maitland, Nova Scotia, a son of the late Mr. and Mrs. Adam Roy, and was educated in the schools of Hants County and carried out his medical studies at Dalhousie University, graduating in 1910, and received his B.A. in 1903. He first practised at Port Morien and moved to North Sydney in 1912. Besides his widow, the former Lillian Moffatt of North Sydney, he is survived by four sons, Dr. Wallace M. Roy, radiologist at the Halifax Infirmary, Halifax, Sub-Lieutenant Kenneth Roy, R.C.N.V.R., Lex and Douglas, medical students at Dalhousie, and four sisters. Doctor Roy was a member of the Cape Breton Medical Society, The Medical Society of Nova Scotia and the Canadian Medical Association. He was a member of Royal Albert Masonic Lodge of North Sydney and a past master of Port Morien Masonic Lodge and a member of the Cape Breton Curling Club. He taught school in North Sydney in 1905.

Doctor Joseph James Fraser Macaulay of Sydney, died in the New England Baptist Hospital, Boston on July 3rd, following an operation in the Lahey Clinic, at the age of seventy-one. He had been unwell since early in the year, and received treatment for a time last winter in Montreal. Doctor Macaulay was born at South Side River Deny's, Cape Breton, son of the late Mr. and Mrs. Malcolm Macaulay. He was educated at Pictou Academy and graduated from McGill University in 1896. His first practice was at Orangedale, C. B., and later he was appointed physician at the quarries of the Dominion Steel and Coal Company at Marble Mountain where he remained for a number of years until he moved to Sydney in 1916 and continued in active practice until February of this year when ill-health forced him to give up his work. He was a member of the Cape Breton Medical Society and of the I.O.O.F. Lodge at Marble Mountain. Besides his wife, the former Miss Lena MacDonald of South Cove, Little Narrows, he is survived by two sons, Doctor Malcolm J. Macaulay and Fraser Macaulay, both in Sydney, and three daughters.