

The Nova Scotia Medical Bulletin

OCTOBER 1959

EDITORIAL BOARD

DR. S. J. SHANE, Halifax
Editor-in-Chief

DR. J. H. QUIGLEY

DR. J. O. GODDEN
Associate Editors

DR. J. L. FAIRWEATHER

DR. C. J. W. BECKWITH
Managing Editor

DR. L. C. STEEVES

Representative, Post-Graduate Division, Faculty of Medicine, Dalhousie University

Corresponding Members—Secretaries of Branch Societies

OFFICERS OF THE MEDICAL SOCIETY OF NOVA SCOTIA AND THE BRANCH SOCIETIES

The Medical Society of Nova Scotia

President	- - - - -	DR. W. A. HEWAT, Lunenburg, N. S.
President Elect	- - - - -	DR. F. J. GRANVILLE, Stellarton, N. S.
Immediate Past President	- - - - -	DR. H. J. DEVEREUX, Sydney, N. S.
Chairman of the Executive Committee	- - - - -	DR. D. I. RICE, Halifax, N. S.
Treasurer	- - - - -	DR. A. W. TITUS, Halifax, N. S.
Executive Secretary	- - - - -	DR. C. J. W. BECKWITH, Halifax, N. S.

Branch Societies

(From Antigonish-Guysborough to Western Nova Scotia).

Antigonish-Guysborough Medical Society—President—DR. A. ELMIK, Canso, N. S.

Cape Breton Medical Society—President—DR. G. W. SODERO, Sydney, N. S.

Colchester-East Hants Medical Society—President—DR. D. F. MACINNIS, Shubenacadie, N. S.

Cumberland Medical Society—President—DR. K. V. GASS, Pugwash, N. S.

Halifax Medical Society—President—DR. J. W. MERRITT, Halifax, N. S.

Lunenburg-Queens Medical Society—President—DR. J. B. CROWE, New Germany, N. S.

Pictou County Medical Society—President—DR. J. A. F. YOUNG, Pictou, N. S.

Valley Medical Society—President—DR. FRANK W. MORSE, Lawrencetown, N. S.

Western Nova Scotia Medical Society—President—DR. G. V. BURTON, Yarmouth, N. S.

Affiliated Societies

Nova Scotia Association of Radiologists—President—DR. C. M. JONES, Halifax, N. S.

The Nova Scotia Society of Ophthalmology and Otolaryngology—President—
DR. L. F. DOIRON, Digby, N. S.

Nova Scotia Society of General Practitioners—President—DR. A. G. MACLEOD,
Dartmouth, N. S.

Nova Scotia Chapter of The College of General Practice—Chairman—DR. J. R. MACNEIL,
Glace Bay, N. S.

Nova Scotia Division of the Canadian Anaesthetists' Society—Chairman, Local Division—
DR. A. S. MACINTOSH, Halifax, N. S.

"THE VIEW FROM THE OTHER"

by

J. W. Reid, M.D., M.R.C.P.

Address to Luncheon Meeting,

106th Annual Meeting

THE MEDICAL SOCIETY OF NOVA SCOTIA

June 25, 1959

It is the human foible of weakness and vanity that entraps a man into the making of a speech. It is a weakness which refuses us the strength to deny our pride, and vanity which refuses us the honesty to admit that we have not a thought in our head worth uttering. So it is that I commend to you the title of this talk as an ocean in which you can flounder at will, if you are ever weak enough and vain enough to be caught in such a net. It is my hope that it will be a gentle if sometimes a trifle acid post prandial eructation offered as an oriental compliment to our hosts The Cape Breton Medical Society. The title suggests a view and a vantage point, the view being largely a look at ourselves and our problems and the vantage point from the other side of the tracks! I hasten to assure you that the views are not those of Organized Medicine, or any persons or things mentioned or maligned, but are purely those of the speaker.

The last time I had the honour of speaking to a gathering of The Nova Scotia Medical Society in Cape Breton the causeway was nearing completion and we were so concerned with what a solid and permanent connection with the mainland would do to the romantic legends of the Island that our hearts and minds were filled with a myriad thoughts about the beauty of this charming place. So many indeed were the thoughts that I knew I could never manage to speak them all from memory so I carefully wrote them down to read at the dinner. Having some difficulty with vision I arranged with the Secretary to have a lectern on the table to bring my notes within visual range. You can imagine my chagrin when the speaker immediately preceding me (who had been making the same speech, letter perfect, for some weeks all across Canada) removed the lectern with a confident flourish, saying, "We won't need this thing, get it out of the way." It landed in the hands of a haughty waiter, who carried it with a disdainful curl of the lip out of all sight and hope to the kitchen. The result was that I never got to say most of the fine things I had in mind, which no doubt was a good thing. The causeway got finished; Cape Breton is now so snugly superior that praise has a flat and inadequate ring, and as is said of the naughty child:

Oft times when praise and pleading fail

The stinging nettle will prevail!

Time was when Nova Scotia was the most distinguished Province in Canada, distinguished for intellect, brawn and beauty by the men of Cape Breton, distinguished for pure intellect by the men of Pictou and distinguished for intellectual purity by the men of the Valley, for, though the rest of Nova Scotia might provide an occasional mayor or councillor, it was to the Valley the Nation looked for its Prime Ministers and Ministers of State. But our greatest distinction lay in being the poorest, most depressed, fightingest province in the Dominion, and mountains of paper have been used to print the endless reports of the endless Royal Commissions reporting on ways to alleviate our distress and hush the clamour, whose recommendations are seldom read and never implemented. And all the while we would go on crying our poverty

with an almost joyous frenzy, expecting, wanting nothing except the puckish delight of embarrassing our masters a little!

Now all this is changed. We have been the victims of a dastardly upgrading, not through the generosity of Ottawa, but through the activity of a little copse who grew to a tough thicken, name of Joseph Smallwood. This man has led his province to displace us as the poorest, fightingest province in the Dominion, and we are confused by a voice that is louder than our own and resentful of a poverty deeper than our proudest boast! And Mr. Smallwood is sure that his grievance is just.

Anyone who remembers Dickens' novel *Nicholas Nickleby* and recalls the great promises of good food, comfort, learning and spending money which the proprietor of "Dotheboys Hall" caused to be publicized in the London press, cannot blame Mr. Smallwood for feeling that he has been taken in, in a different age, place and way, by a proprietor just as unscrupulous as the terrible Wackford Squeers, whose Canadian counterpart holds sway in the city of Ottawa in a beautiful stone towered and carilloned edifice known as "Diefenboys Hall." There seems no doubt in Mr. Smallwood's mind that some of the surly masters of this hard school are just as quick and nimble with the switch (political or birch), and just as unreasonable as Mr. Squeers himself.

Nova Scotia must bear some of the blame for Mr. Smallwood's unhappy position, for we, who nearly a century ago, entered the enticing garden of Confederation only to hear the iron clank of the confederate gate lock shut behind us, and see the door to the warmth, comfort and prosperity of the inner sanctum of industry slammed shut in our faces forever, have lived to see a flourishing trade done to its death by the hand of a murderous tariff; have seen a proud and prosperous people impoverished to satisfy the greed of our Upper Canadian masters; we who for nearly a hundred years have received a stone in the teeth every time we asked for a mill to grind our flour; we who have bowed under a burden of taxation levied to provide services for millions of dollars worth of property, confiscated tax free, in the name of the nation; we who have implored a long succession of federal governments for some re-distribution of industry or some regionalization of tariffs and taxes, have found them too weak to oppose the power of Central Canadian business; we who knew all these things, sent not a single delegation to Newfoundland to tell them the truth, that for the Provinces of Eastern Seabovia (so named for our similarity in poverty to Al Capps' Lower Slobovia) life in Confederation consists in subsistence on crumbs from the Master's table, supplemented, in times of impending elections, by meagre alms and generous promises. Better to have remained a proud stranger at the gate, free to sneer or starve or move along, than to be a poor chattel, bound to a confederation of greed and injustice, used, kept and despised, like a harlot!

When I think how this courageous man, this valiant Premier, is almost single-handed struggling with Ottawa to secure the recognition and rights of those Atlantic Provinces, and how he came to Halifax to plead with Nova Scotia for moral, spiritual and political assistance in his efforts for Newfoundland, only to find our public men engaged elsewhere and even the threat of a union delegation from Cape Breton to picket the building in which he was to speak, I realize that we have been so cowed by all these years under the lash of national politics and international unionism, that there is not, even in Cape Breton, The Isle of the free and the home of the brave, a voice to be raised in his support! And I cry:

For shame Isle Royale! whose every village still
Owns men who suit their actions to their will,
Who yet should strike, with just Cape Breton hand,
A blow to succour, not to punish Newfoundland!

In the face of our strange indifference, it is not much wonder, come election time, that Mr. Smallwood seems disinclined to send many of his children to school at Diefenboys Hall, for the sting of an unjust "switch" is not a punishment that a free and able man esteems or endures!

If we are not wise enough to support Mr. Smallwood in his struggle to lift his province above the level of the 'have not' areas of the world; if we do not believe that an 'old colony' plan for Newfoundland is just as important, and worth as many millions as a 'Colombo Plan' for Ceylon, then indeed are we just as stupid, just as weak and undeserving of first class citizenship in Canada as the rest of the Nation takes us to be.

Let us turn for a moment to a different view. How strangely variable do we see the accents of punishment! How numerous the vagaries of justice! How often do we see the heaviest punishment fall upon the frailest shoulders, or missing entirely the guilty, crush the innocent! So often the unknown thief of a trifle is sent to prison for three years, while the popular embezzler of an hundred thousand serves only two! And the murderer, the cold blooded killer, is so hedged around with protective court procedure that it is almost impossible to get a conviction. If at last he is found guilty of murder by a jury of honest and conscientious men, the 'do-gooders' in our society raise such a hue and cry that it is becoming almost a capital offence for a judge to do more than compliment the criminal on his cleverness!

Abolish the death penalty they cry—in the name of God and mercy abolish the death penalty. "Vengeance is mine said the Lord" Aye! "Vengeance is mine" saith the Lord, and God is the final Arbiter to judge our souls when we are dead. Who then are those people who would keep alive a man found guilty of murder and keep waiting for a lifetime the Judgment of an angry and impatient God? Would you have peace of mind while the murderer of your child lived, to be paroled, maybe, in ten or fifteen years by a soft and forgetful public, to kill perhaps again at some full of the moon?

Who and what are these 'do-gooders'? They are the refreshing drops of water who surely, though slowly, wear away the very foundation stones of our society; they are the golden sunbeams, grown overhot, that wilt the choicest flowers in our garden of law and order; they are the wind that blows away civilization's first and surest protection—the knowledge, indeed the certainty, that duly elected or appointed persons will make sure that the laws of civilized society will be obeyed or, if broken, justly punished; they are the kindly, gentle, misguided destroyers of organized community life, for they know so little of men and remember so little of history that they do not comprehend the hundreds of years of patient trial, education and persuasion it took to prevail upon mankind to give up the system of family and tribal justice upon which primitive society depended for security and to abrogate to elected, designated and sovereign authority the duty and responsibility to find and punish an offender. Nor do they understand that it is the wise alone who are capable of discerning that impartial justice, untinctured by emotions however generous, is in the end the truest mercy.

So be it that if these well intentioned people continue to weaken the hands of impartial justice, if they continue through their highly organized and aggres-

sive activities (financed, one might even think, by grants in aid from the welfare funds of Mafia and Murder Inc.) to engender in decent law abiding citizens the fear that authority is no longer sovereign and that criminals will no longer be adequately punished, than they are so far guilty of corrupting and degrading our society.

A few days ago I received a letter and a card which read: "Prison reform is everybody's business." It is my belief that prison reform is the business of the State. It is character reform that is everybody's business, and character reform does not take place any more readily in a soft, clean cozy prison than it does in a hard cold, brutal prison, for character is moulded best by formation not by reformation and it is most firmly shaped in the wholesome atmospheres of home and church and Sunday School, of youth groups, scouts and games. If the money and efforts of these kindly people could be channelled in these directions then better living and finer character would minimize our prison population.

It is strange that workers are so ready to alleviate the lot of the criminal and so unwilling to teach in Sunday School, or give one night a week to cubs, or scouts or other youth work.

It is time that our Society stepped across the tracks and took a long and critical look at itself from the other side for it has been the tragedy of every civilization that beauty, gentleness and reason come first to mourn at the tomb.

The story is told of a young lad, who having finished his matriculation was preparing to go away to University, and though inclined to Medicine was not yet fully committed. He thought to ask the opinion of some of his townsmen and so approached a local merchant of experience who had received his business training in a large city, and he asked, "Mr. Broad, I am going away to the University this fall and am thinking that I might study to be a doctor; what do you think of doctors?" "Doctors Johnny?" he replied, "Why they're the worst trained, fullest qualified, best protected, highest paid humbugs in the country" and he burst into a great gust of laughter at the hugeness of his own joke. "Why Johnny. . . ." he started to say, but Johnny had walked away, thoughtful.

The next day he met a lawyer of their town, a native of Pictou County and he said, "Mr. Sharp, I am going to the University this fall and am thinking of studying Medicine, what do you think of the medical profession?" "Why Laddie" said the lawyer, "I liken the medical profession to an overburdened cart, dragged by the twin bulls of pride and ambition through the muck of an 18 hour working day to a broken rest and a poor reward—Now take the Law Johnny. . . ." but Johnny had walked away, thoughtful.

On Sunday after church, he had the opportunity to speak to his clergyman and he asked, "Mr. Good, I am going away to the University this fall and am thinking of studying Medicine; what do you think about being a doctor?" And the Clergyman, who was a Cape Breton boy, and knew about doctors, replied, "My boy, a good, kind and conscientious doctor comes more nearly to walk in the footsteps of Jesus Christ than is given to any other living creature, the Clergy not excepted—why my boy, not even the Church. . . ." he started to say, but Johnny had walked away, thoughtful.

I should go on with the story and tell how Johnny went on to the University and became a great and famous doctor, even Sir William Osler, but that would be a lie. He did go on to the University, but he read in the law and

became a brilliant barrister who delighted all the rest of his days to make doctors miserable in the court room. Today, we have many things besides lawyers to make us miserable, we have public relations, problems with medical education and specialization, socialism and a host of others.

There are too many young men like Johnny deviating from the study of Medicine today, and their defection is beginning to cause much thought and grave concern to all. Has Medicine lost its fascination for the young? Perhaps, for it is no longer the confident, burgeoning discipline of 50 years ago, sure of its method, its place in the community and its goal, but is instead a whirling confusion of science and art, spinning in an ever tightening vortex of uncertainty, at the centre of which is socialism and on its fringe a tangle of twisted hopes and fears mingling with the unsolved problems of education, specialization and remuneration, all orbiting dizzily about the welfare state.

We seem, then, to have two fundamental problems in medical education. First, to get young men into the school, and second, what to teach him when we get him there and toward what goal. Concerning the first, certain factors are obvious and hinge upon the length and resulting high cost of medical education, the improved economic prospects in other professional fields and the relative drudgery of the medical life. Other less tangible factors are the fear that the medical course is too hard for a man of average intelligence; that in the present day general contempt for the suckers of the learned professions, Medicine has suffered most, because it is the hardest discipline; the steadily decreasing freedom of choice and action, which was once Medicine's second greatest drawing card, and the loss of the patient's reverence and regard which was the root of the only real satisfaction in medical practice.

Is there anything that we can do to alter these trends; perhaps a few.

1. We can stop making pretend that Medicine is too difficult for any but the genius to learn, for it is after all only a nod of the head from a genius to the fool.
2. Let us shorten the course by an honest weeding out of the things that, though of intense scientific interest, bear only obliquely on the practice of Medicine. Remember the sick, they want healers, not scientists.
3. Let us see to it, that if we cannot retain the freedoms of Medicine, we ensure, in its place a way of life less obnoxious to the youth of today.
4. Let us try to regain for the medical profession something of the glamour which dignity and austerity once made fascinating to the young.

What about the medical curriculum? All the discussion that goes on concerning it, must indicate some desire for change. Small alterations are being made at the bottom, and insignificant changes in the middle, and at the end, another year is added. Why is this? It is because no meaningful or significant alteration in the course can be made until the nature of the vehicle which is to carry medical knowledge to the sick is clearly defined, for not until the vehicle is known, can its motivation be correctly powered. We cannot plan intelligently for the education of a doctor, until we know what kind of doctor is going to be required.

Medicine and medical educators must commit themselves soon to some definite plan for future medical practice. It seems to me there are three alternatives:

1. Continue the present time-honoured system of general practitioners, aided by the specialist.
2. Medical care by groups of specialists.
3. Medical competition between general practitioner and specialists.

Only when we have firmly fixed on one of these alternatives can any real improvements be made in medical education. The opinion of the Medical Societies, and of interested lay bodies and government should be sought for and considered by those who have responsibility for the final decision.

If the first alternative is chosen, then the principal changes will bear on post-graduate education and the training and control of specialists; such as:

(a) All must have a specified number of years in general practice before being permitted to specialize.

(b) Hospitals must be prepared to pay adequate salaries to residents in training so that the families of these older trainees can be provided for.

(c) Specialists must be trained to act as pure consultants.

(d) Their numbers must be controlled in every field so that they do not have to engage in open competition for a living, for as their numbers in the community increase, their stature must inevitably diminish the prestige of the G.P. and no amount of lip service will ever alter this fact.

Dr. Oliver Goldsmith, two hundred years ago, observing how the newly rich manufacturing class in England were dispossessing and driving out the old-established families throughout the country, and seeking for some way to restore the balance, wrote in his poem "The Traveller" these lines, which in a different age, place and sense are somewhat applicable to our specialist, general practitioner relations today:

I only would repress them to ensure;

For just experience tells, in every soil,

That those who think must govern those that toil;

And all that freedom's highest aims can reach,

Is but to lay proportioned loads on each.

Hence, should one order disproportioned grow,

Its double weight must ruin all below.

It does seem obvious that uncontrolled specialization will eventually destroy general practice.

If the second alternative is chosen, that is medical care by groups of specialists, then the entire structure of the Medical curriculum must be altered. It must be changed to greatly shorten the period of training for basic medical qualification and specialist training must peel off early in the course to follow its own curriculum to a degree in that specialty—in the same manner as dentistry does today. It is no more necessary for the gynecologist, the ophthalmologist, and urologist to be fully trained in the whole discipline of Medicine, and then having absolutely no experience in it, go on to train in a specialty, than it is for the dentist, who has been trained in the scientific method, and speaks to us on even terms in anatomy, pathology and biochemistry.

If the third alternative is chosen, the G.P. in competition with the specialist, the training will have to be planned in stages of competence throughout the years of practice, each stage with its appropriate qualifying degree. There will be a five or six year (from high school) basic qualifying course, the student to be brought back after a specified number of years for the next stage (each stage arranged to be compatible with the realities and responsibilities of family life) and so on over the years until he may, if he wishes, be eventually certified in the specialty of his choice and aptness.

This obviously fits into, in fact is but an extension of the present rapidly growing post-graduate training programme. It reduces to compulsion the prideful boast of the earlier doctors, that he was (by free choice) a student all his life.

So we may live to see the doctor trained toward a knowledge of Medicine from the cradle through his brief lifetime, only to sink into an early grave, wet, not with the tears of grateful patients, but with the torrent of medical education that follows him over the brink of eternity.

Will there be young men willing to carry such a cross for the good of mankind? There will be such.

George F. Dell wrote 18 lines of advice to his son coming into manhood, and it seems to me that they are particularly applicable to young men of the medical profession, whether they be students, general practitioners or specialists. He wrote:

Would you be wise? then do these simple things
 Plant many seeds, in all your many springs;
 Marry a wife, and either love or lie
 A little every day you will not spend;
 Choose three or four (no more) to call you friend,
 And these tough-minded, careful critical—
 Trust these, but demonstrate respect for all;
 Do every day something you hate to do
 And something you prefer; by night renew
 Your mind through prayer; be ever discontent
 With your perfection of accomplishment;
 Diminish no-one, act so that no curse
 Is justified, and treat no fellow worse
 Than you would have him treat you, if by grace
 Of God there should be an exchange of place;
 Last, live the day unfeared, having eyes
 Only for life—let death be by surprise.

**ADDRESS TO MEDICAL SOCIETY OF NOVA SCOTIA
 ANNUAL MEETING 1959**

R. MacD. Black, LL.B., Chairman

NOVA SCOTIA HOSPITAL INSURANCE COMMISSION

Those of us who either served on the original planning commission or are members of the present Nova Scotia Hospital Insurance Commission have much to be grateful for from your profession. We feel that it is very necessary and proper to give you all the information we can. We are honoured by your invitation to report to you today.

This whole plan could have been highly controversial. There are still areas of doubt and conflicting opinion. It is most gratifying that they are so few.

You can take pride in the fact that many individual doctors participated in planning and organization. You can share gratification in the fact that your acceptance and implementation of the Plan has been responsible, in large measure, for the extremely low incidence of friction.

As to the whole picture to date, I am confident that the institution of this Plan was not only necessary, and was one of the greatest boons our province has ever received, but also that it did introduce all the services that could properly be given at the time.

Nevertheless, it does need understanding. Many of your members have been able to take an active part and know the Plan thoroughly. Others, perhaps most of you, simply have not had the time and opportunity to learn all the many complicated details. Yet complete understanding by all in your group will mean tremendous benefit.

For these reasons we hope now to advise you of some progress figures to date, the role your profession has played, to discuss the difficult problem of overutilization and the often misunderstood concepts of just what are Plan cases and just what is necessary nursing. Again, the whole field of new construction is a vital one to you and ought to be discussed too.

It is doubtful if any other scheme in the history of this Province involved so much change, reflected on every man, woman and child to such an extent, and, at the same time, required such large expenditures of provincial and federal funds in the very first year. Therefore, at least some statistics ought to be studied.

Hospital items exclusively under the Plan will cost in the vicinity of \$14,000,000 in the first year. As to our own share, that is 1959 cost to the Nova Scotia Government, the figure is expected to be around \$6,500,000 as shown by budgets to date. It is to be remembered that hospital expenditures for some time have been climbing about 10% per year over the whole continent.

Returning to shareable items, or purely Plan costs, the per diem will be around \$14.68; this is worked out by dividing everything approved so far in budgets by the expected number of patient days.

Results so far indicate a total of one million in-patient days for Plan hospitals. New borns will likely reach 100,000 days care.

Just about 33,000 adults and children were admitted to these hospitals during the first four months. The same months indicate a level of 80,000 out-patient visits for the full year. In other words, if no one applied twice somewhere between a third to a quarter of our people will receive Plan treatment in 1959.

Length of stay is up, but it and some other figures are not yet sufficiently accurate for comparison.

At any rate, it is fully apparent that this is a vast scheme and of significant importance to us all, layman and practitioner alike. It is very big business for a province of less than three quarters of a million population.

Being very conscious of this magnitude, I can say with complete sincerity that the Plan could not have been contemplated, could not have been put into operation, and certainly could not have enjoyed the success which has resulted without the unstinted cooperation and wise counsel of your profession.

Many aspects of the Plan are purely medical; all phases have some medical connotations. Naturally, hospitals cannot give service without doctors. But more was required and this you gave freely.

The planning stages embraced many subjects; from the services to be given and the number of beds and facilities required to studies on financing methods. Doctors participated in every phase. They served on the original provincial committee, on the Planning Commission and its advisory committee and as consultants to all.

We can single out another group; not for any unfair comparison, but as a leading example of selfless effort and concrete result. This group is your own Health Insurance Committee. I think it is significant that two of its original members now serve as Hospital Insurance Commissioners. Others are consultants to us.

Following another of your recommendations there are three doctors on the Commission. Two others process admission-discharge records. Six serve as consultants in various fields. A total of twelve are on the Professional Technical Advisory Committee advising on such diverse and particular specialties as psychiatry, medicine, surgery and general practice.

Most of these matters are relatively well known. Unfortunately there is an even wider field of your service which is practically unknown but which does merit the fullest public awareness and gratitude. I refer to the work of all those doctors who contribute so many long hours on the Medical Standards Sub-committees now active in every hospital. Their role cannot be overstressed. Here it is that the patient, the taxpayer, the citizen has his interests safeguarded in the first real sense.

Here it is that he gets first protection from the waste and overexpenditure which would follow abuse of the Plan; and here it is that standards of services under the Plan are first watched and maintained.

All of us concerned do have this double responsibility. Our people must have the very best in hospitalization that our resources can afford; but these resources must not be squandered!

Our Nova Scotia approach to the problem is unique. It has been felt from the very first that those best qualified to bear the responsibility are those best qualified to judge. Hence those who are acting are chosen from the very doctors who are actually practising in the hospital concerned.

In our province all the matters of admission, length of stay, drug usage and level of diagnostic procedures have been controlled in the very first instance, by those who admit to hospitals themselves and who are directly answerable to the patient as an individual. The control in this sense has not come from some cold, distant and perhaps unknowing central agency.

Your Society proposed that this phase be a purely medical one. Your members are discharging the responsibility. All of us can take comfort that the recommendation was adopted.

I hope that there will soon be public recognition of the long hours these men spend and of their wise decisions, and that with it will go an awareness that the time is given freely, voluntarily and without remuneration.

I spoke before of frustrations and misunderstandings. There have certainly been benefits for you, but we are very much aware that there are new burdens too. Among these has been your difficulty of positively defining to your patients, and others, the technical concepts of "active hospital care" and "necessary nursing." For complete understanding they require broad medical knowledge. Thus they are the points that have often confused laymen. Try, in a sentence or two, to fully explain just what a sick man is. But this is just about what people have been asking you to do every day.

The Plan does have restrictions. Primarily they stem from the provisions of the Ottawa Legislation. Although there are 45 hospitals and a facility giving insured services here, all are confined within the insurance limitations.

If a patient no longer requires the services of these hospitals, whether or not he may still not be completely well in the layman's sense (and if his requirements can be equally well be served elsewhere) then he ceases to be covered by the Hospital Insurance Plan.

The Plan is wide, but not all embracing. Social and economic considerations simply cannot be applied. It is an active hospital measure; if a patient no longer needs active hospital care he at once ceases to be covered by the Plan.

By Legislation, by Regulation, by Agreement this must apply regardless of whether or not the required home care or nursing home care is available.

In the days before a Plan, our hospitals ensured that every patient, even those unable to pay, had all the nursing service he or she medically required. It is a magnificent tradition and it is continuing.

The difference now is that the hospital can include the additional nursing in its budget considerations. And the service no longer need depend upon charity or sacrifices in time by nursing personnel; nor will it result in hospital deficits.

But necessary nursing does not mean private duty nurses. On the contrary; it does mean that hospitals can provide nursing above that normally required by the average ward patient and for the purpose employ more nursing personnel, on a temporary basis, but only if this attention is warranted by sound medical reasons.

The additional nursing may only be a few minutes a day, or it may mean three-shift around the clock attention, as for the dangerously ill post-operative case.

But it is staff nursing. Hospital staff nursing. It is still staff nursing whether the personnel is retained for a short time or permanently. It is not private duty nursing.

It must be necessary according to the best medical standards. It is authorized by the hospital. Never is staff nursing necessarily devoted exclusively to one patient.

The third most misunderstood area, hospital construction, is also susceptible to controversy if the full background is not known.

We believe this Plan will be a boon to the profession and will provide adequate hospitals in which you can work. But when we say this, and at the same time lament that there is still a shortage of some 2000 beds, then your proper reply is—When are these beds going to be provided?

For some time, and quite recently, doctors have asked me why the province went into a Plan at all before the complete facilities were ready? With patients and municipalities unable to pay their hospital bills, with hospitals showing deficits totalling well over a million dollars and construction at a standstill, implementation of the Plan simply could not be delayed. This is accepted pretty generally now and I will not belabour the point.

However, what may not be known is that a plan itself provides impetus for construction. We now have a resumption of construction grants, municipal contributions and low interest provincial loans. It is unlikely that all of these would have come without the impetus of the Hospital Insurance. I feel confident that the required building will follow; just as it did in the provinces which embarked on the scheme years earlier and which then also had shortages.

Already we have construction proposals from some three fifths of our hospitals representing possible increases of some 1300 beds. But there is still the question: When will these new beds be available?

There is a short answer. Experts reckon, as a general rule, that just as much time is necessary for good planning as is involved in the actual building. Bear in mind that an average hospital, say of 100 beds, may take from a year and a half to two years to complete.

Here, in our province, while new construction was well nigh at a complete halt, we fill about 3 beds per thousand population short of accepted requirements. One of our regions is down to 2.2 beds per 1000 people instead of an accepted optimum of 6.9.

Hospital owners have an extraordinarily wide range of problems to settle before they start to build.

First, their proposals have to be integrated with the best plans for regional and provincial development.

Next, not only does provision for actual patients and staff have to be integrated, but the services to be given just receive the same careful scrutiny. Among the considerations are decisions concerning level of diagnostic services, rehabilitation, what will be the maternity requirements, surgical, medical? How much space is necessary for paediatrics? Now much for out-patients?

Governing all is the estimation of just what area the hospital may be expected to serve; how many people in it will stay home and how many will go elsewhere for hospitalization? Remember that these patterns do change. Just what services might be more efficiently or economically given in another centre?

All these decisions require numberless conferences. The medical staff must plan and report. Similarly with administrators, trustees, nursing staffs and the representatives of special services. Hand in hand, and a beginning and an end, go the deliberations of those providing the financing.

I am positive that there is not one group yet but has changed its mind on at least some points when faced with all the other considerations. I even know of a medical staff or two that has gone through this process.

Administrators and medical staffs want to ensure that there will never be any shortage of facilities. Financiers may go to the other extreme in the fear that too expensive a plant is emerging.

When any of these opinions have conflicted delay has followed. This province gives a \$3000 grant for new construction, Ottawa \$2000. Both must approve, but first of all the various consultants in the particular fields must study and report. Usually there are conferences with the local people and visits back and forth.

Finally the architects and contractors must steer a course through all this and come up with ultimate solutions.

All in all, unless disaster is courted, it cannot be a hasty process.

Hospital planning is a good deal like proofreading, and there is an ailment here, although not one brought to your attention, called proofreader's blindness. Despite long and cautious scrutiny by many competent people mistakes, that ought to be obvious, will persist right up to the end.

For example, and not imaginary ones, these are some things which show up in blueprints: out-patients routed through kitchens, clean and dirty laundry intermingled, maternity sections placed right next to operating theatres, tubs and toilets forgotten. When do they show up? Generally well along in planning, and the program is slowed.

The requirements are new to most board members and even to some architects. Plans have arrived down to too small a scale for clarity or there haven't been enough of them. Details, probably well known to the planners, have been omitted and those unfamiliar with the particular plans cannot follow the prints.

And again, from a low of relatively few plans, provincial and Ottawa scrutineers have been inundated by many; all practically arriving simultaneously.

Nevertheless, we do assure you that construction has the highest priority. Everything is being done to speed the program. We do need beds and we need them now. But a few month's careful planning can save a half century's mistakes. And mistakes which can be eliminated by good planning are costly indeed to rectify once they are in terms of concrete and brick.

Spinal Accessory Nerve Palsy In Surgical Practice*

S. W. A. Gunn, M.D., M.S., F.A.C.A.**

Damage to the spinal accessory nerve in war and in multiple injuries is not uncommon. The resulting lesion may be composite, as in the 'jugular foramen syndrome', or isolated, causing paralysis of the trapezius. In routine practice, however, the majority of injuries to the nerve follow operations in the neck. These procedures are very common and are mostly in the field of "minor surgery," such as removal of cervical lymph nodes or biopsies. As the operation is "minor", the resulting injury should be regarded as being all the more serious.

Surgical Anatomy

The spinal accessory, accessory or 11th cranial nerve leaves the cranial cavity via the jugular foramen. It soon divides into two main portions or branches—the one internal and the other external. It is the latter branch that we are concerned with in paralysis of the shoulder.

The external branch negotiates an oblique course in the posterior triangle of the neck. It may be subdivided into 3 parts: (a) presternomastoid, (b) sternomastoid and (c) superficial, from the lateral border of the sternomastoid until it enters the trapezius (Fig. 1). In this region the nerve is almost subcutaneous and therefore particularly vulnerable. In calibre, the nerve is quite thin; during surgery the operator rarely recognizes that he has injured it, especially that variations are not uncommon.

The posterior cervical lymphatic system runs in close proximity to the nerve. Indeed one of the chains intimately accompanies the nerve and carries the same name. The importance of these cervical glands in tuberculosis, in infections and in malignancy is well known.

Physiology

The internal branch of the spinal accessory nerve controls—via the vagus—the intrinsic muscles of the pharynx and the constrictors of the larynx. The external branch innervates the sternomastoid and the trapezius muscles. The action is purely motor.

The trapezius elevates the shoulder and draws the scapula towards the midline. It also contributes to the inclination-rotation movements of the head. The rôle of the trapezius in the function of the scapulo-humeral joint has been well studied—particularly by Inaman *et al*⁴. The upper third of the trapezius, the levator scapulae and the first digitations of the serratus anterior form a postural unity which supports the shoulder passively, elevates the shoulder actively and helps in the rotation of the scapula.

*From the University Surgical Polielinie (Prof. R. Patry), Medical Faculty of Geneva, Switzerland. Work done during the tenure of the University's Exchange Scholarship.

**Surgeon, Bay Medical Clinic, Senior Staff The General Hospital and St. Joseph's Hospital, Glace Bay, Nova Scotia.

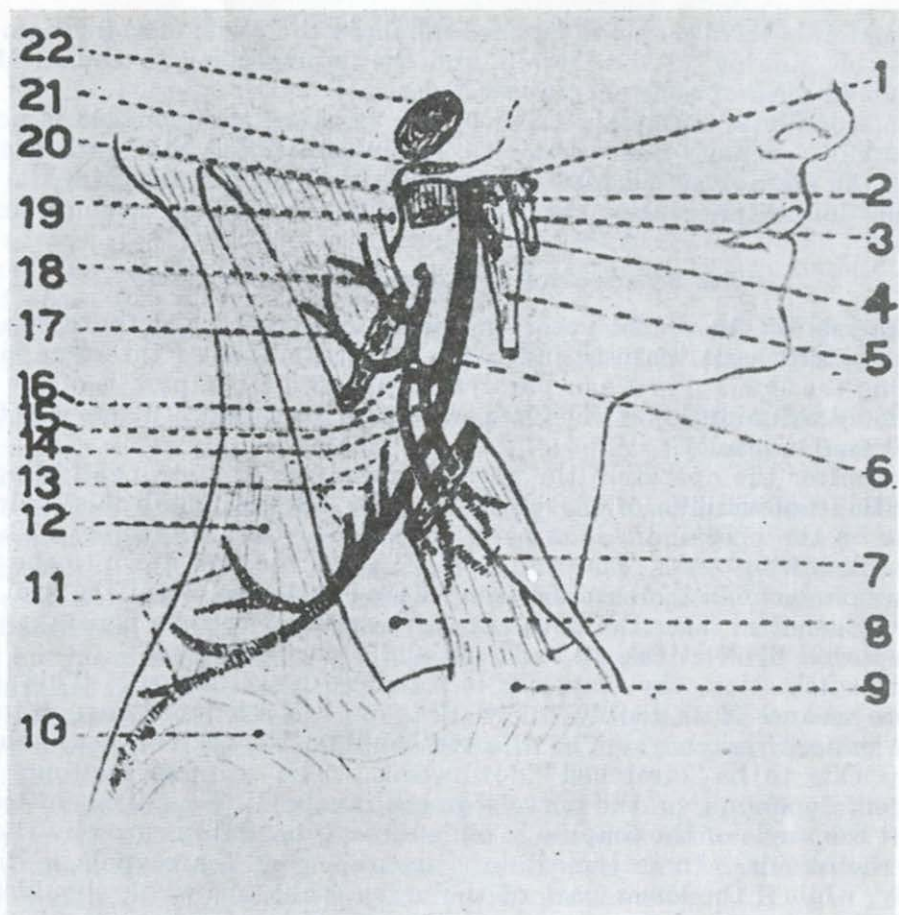


FIG. 1

- Fig. 1. 1. Spinal accessory nerve emerging from the jugular foramen. 2. Communication of the spinal accessory nerve with the vagal ganglion. 3. Glosso-pharyngeal nerve. 4. Internal branch of the spinal accessory nerve. 5. Vagus. 6. External branch of the spinal accessory nerve. 7. Sternomastoid muscle. 8. Lateral or posterior cervical space. 9. Clavicle. 10. Acromion. 11. Terminal branches of the spinal accessory nerve in the trapezius. 12. Trapezius muscle. 13. Communications with the 3rd, 4th and 5th anterior cervical nerves. 14. Nerve branch to the cleido-mastoid muscle. 15. Nerve branch to the sterno-occipital muscle. 16. Communication between the spinal accessory nerve and the 3rd cervical nerve. 17. Nerve branch to the cleido-occipital muscle. 18. Nerve branch to the main body of the sternomastoid muscle. 19. Mastoid process. 20. Internal jugular vein. 21. Styloid process. 22. External auditory meatus. (Muscles 14, 15 and 17 are constituents of the sternomastoid.)

(Modified after Pauchet and Dupret*)

*Pocket Atlas of Anatomy, Oxford University Press. London. 1948, by courtesy.

The lower third of the trapezius, together with the lower digitations of the serratus, form the inferior rotatory force of the scapula.

The middle third seems to fix the scapula in the plane of abduction. This explains the 'sinking' of the scapula and the impossibility to abduct the arm above 90° in case of accessory nerve palsy.

Functionally, the damage done to the sternomastoid muscle is not very important in accessory nerve lesions. It must be noted that both the trapezius and the sternomastoid receive branches from the cranial pairs C₂, C₃ and C₄. This double innervation seems to afford a false security to some surgeons.

The Syndrome of Accessory Nerve Palsy

Paralysis of the spinal accessory nerve represents a definite syndrome. There is paraesthesia, paresis and pain in the shoulder of the same side and pain along the arm. Paresis or paralysis of the trapezius, paresis of the sternomastoid and a diminution in the force of the arm are noted. There is deficiency in functional capacity.

Soon after the operation the patient complains of a strange feeling in his arm, with impossibility of elevating it. He cannot comb his hair. The shoulder on the operated side appears to be lower than its fellow. There is a deep and 'gnawing' pain; 'pins and needles' along the arm down to the fingers. All these phenomena increase on exercise and decrease when the arm is supported. Sooner or later the pain and paraesthesiae become constant. Of 16 cases reported by Norden⁸, 10 had pain and 7 paraesthesiae.

On examination, the trapezius is found to be paralyzed. This is never complete because of its doubly innervation, but it is advanced enough to handicap the patient seriously. The affected shoulder is sunk and that side of the neck appears to be "stretched" downwards. The scapular contours are accentuated, depending on the nerve segment involved; in paralysis of the lower segment the angle of the scapula is pulled upwards and inwards by the action of the rhomboids. In intermediate segment lesions the scapula is displaced laterally, while if the lower part of the nerve is cut, the whole shoulder drops. In all cases the patient cannot elevate the arm above the horizontal (90° from the position of rest) due to poor fixation of the scapula.

The force of the arm is diminished. This is due to a lack of support at the shoulder and not due to damage of the arm muscles as such. The reflexes and the circulation in the arm remain normal. There is no atrophy of the muscles of the arm proper.

In all cases functional capacity is diminished. Hanford³ mentions a patient who was turned down from active service because he was unable to give a military salute! Only 2 out of Norden's⁸ 16 patients could resume work at 100%, while 3 others were declared as being totally incapacitated.

This serious incapacity seems to be due to pain rather than to muscle paresis. Probably pain and dropping of the shoulder are directly inter-related as the pain diminishes when the arm is supported. Traction on the brachial plexus may, therefore, be the immediate cause of pain.

How is the Accessory Nerve Injured?

Lesions of the nerve in the course of multiple injuries are not considered here. In surgery, it is particularly in the course of minor operations in the neck that the spinal accessory is susceptible to damage. In major operations the field is large enough to give a clear view of all structures involved and as

far as removing the nerve in radical neck dissection for cancer is concerned, I believe that the price is worth paying.

In routine surgery, cervical gland dissection for tuberculous nodes is the most common cause of accessory nerve palsy. Wulff¹² mentions 8 cases out of 230 dissections (3%) and according to Hanford³ this incidence rises to 10% (13 cases over 131). Of Norden's⁸ 16 cases, 6 were due to tuberculous gland excision and 4 due to removal of other glands. Mead⁷ encountered 6 cases of postoperative accessory nerve injury, all following minor surgery in the neck. For Oppikofer⁹ this complication remains the principal danger of gland dissection for tuberculous adenitis.

Excision of small, benign tumours of the neck, such as lipomata and sebaceous cysts, is another common cause of accessory nerve palsy. (vide infra)

Biopsies, which are common in the posterior triangle of the neck, are another source of such nerve injury, (Rade,¹⁰). Gale² reports the unfortunate case of bilateral lesions.

The treatment of facial palsy by facio-hypoglossal nerve anastomosis is an example where the 11th nerve is sectioned intentionally. But to create a trapezius palsy, with all its consequences, to correct a palsy elsewhere, seems to me to be illogical—especially when the results of facio-hypoglossal anastomosis (Lodge and Gueukdjian,⁶) are satisfactory. Another instance where the nerve is cut intentionally is in the treatment of spasmodic torticollis (Dandy¹) but results are not as satisfactory.

During operations where visibility is not perfect, the nerve can easily be taken for a vessel. Indeed explorations have, in many cases, revealed ligated but intact nerves.

Other than surgically caused lesions, the nerve may also be damaged by involvement in glandular caseification, in metastatic infiltration etc. I also have a patient who developed accessory nerve palsy at work which involved the supporting of a vibrating drill chuck with his shoulder.

The following illustrative case report shows the most common way in which the spinal accessory nerve is damaged in routine surgical practice:

CASE I. A labourer, aged 63, was seen as an outpatient for a swelling in the right side of his neck. This was diagnosed as a benign lipoma and removed under local anaesthesia. The wound healed normally and the patient was discharged in a satisfactory condition. Eight weeks later he returned, complaining of loss of force in his right arm. Examination revealed an atrophied trapezius and a weak grasp. Damage to the spinal accessory nerve was diagnosed and this was attributed to the minor operation. Physiotherapy was promptly started but recovery was not satisfactory. The case led to complicated medico-legal action. Examined 5 years later, there were all the signs of advanced accessory nerve palsy, as illustrated (Fig. 2). Since the operation, the patient had worked only periodically, and at 50% capacity at that.

Treatment

Every effort should, of course, be made to prevent surgical injury to the nerve. Minor surgery and biopsies are usually entrusted to junior staff and

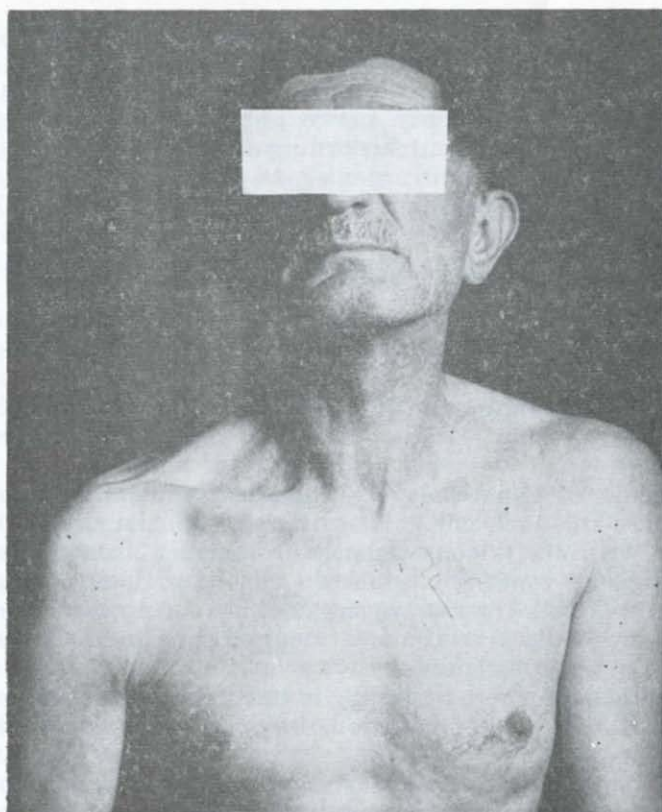


FIG. 2

Fig. 2. Paralysis of the right trapezius following accidental surgical section of the spinal accessory nerve. Note the sinking of the shoulder; the exaggerated supraclavicular notch; the traction on the integuments of the lateral cervical region by the weight of the arm. There is no paralysis of the sternomastoid muscle. Posteriorly, this patient also had a lateral deviation of the right scapula.

this, no doubt, increases the risk of accidents. At operation one may keep away from the nerve or, better still, identify it, remembering always that deviations in its course are not uncommon. Lahey⁵ advises tracing the nerve with electrical stimulation.

It is advisable not to operate in the posterior-cervical triangle if, for example, a gland biopsy can be done elsewhere on the body. In right-handed patients, operating on the left side of the neck is a wise precaution to take. If there will be intentional section of the nerve (*vide supra*) the patient should be warned about the consequences well before the operation.

In case of damage to the nerve, immediate suture should be done—if the injury is recognized during the operation. If diagnosed later, chances of cure are good if nerve suture is done within 1 to 2 months; poor, if done within 5 to 6 months after injury. However, Woodhall¹¹ has reported good results of nerve suture even 12 months after damage. Of 8 cases, this author explored 7. In 4 there was section of the nerve; these were repaired. In 3 cases electrical stimulation having shown an intact nerve, caught in fibrous tissue, neurolysis

alone was successful. Suspension of the scapula and other orthopaedic procedures have also been successful.

In long-standing cases only symptomatic relief can be aimed at. Braces and special supports may help. Secondary arthritic changes in the shoulder joint are common and need special care.

The overall results of therapy in spinal accessory nerve palsy remain poor. The infirmity that ensues is serious. It behooves the surgeon, therefore, to prevent injuries to this important nerve.

SUMMARY

Attention is drawn to lesions of the spinal accessory nerve in minor surgery of the neck. The incidence of these accidents is as high as 11% and the resulting trapezius paralysis causes serious incapacity.

The surgical anatomy of the nerve and the neck is briefly outlined. Hints for the prevention of such accidents are given and the treatment is discussed. The method of choice, in recent lesions, is suture of the nerve.

RÉSUMÉ

L'auteur attire l'attention sur les lésions du nerf spinal à la suite des opérations dans la région latérale du cou. Le taux de ces accidents est estimé à en dessus de 11%. La paralysie du trapèze qui s'ensuit constitue une infirmité grave et diminue la capacité du travail. Des complications médico-légales sont à craindre.

La branche externe du nerf est atteint le plus souvent à la suite des petites opérations courantes, surtout pour ablation de ganglions tuberculeux. Un cas de lésion à la suite d'extirpation d'un lipome est rapporté.

L'anatomie chirurgicale de la région intéressée est passée en revue. Vu la vulnérabilité du nerf, il est souligné que le spinal doit être bien tracé avant toute opération dans cette zone. L'accent est surtout sur la nécessité de prévention de ces lésions chirurgicales.

Le traitement de choix en cas de lésion récente est la suture nerveuse. Le pronostic reste, autrement, défavorable.

REFERENCES:

1. Dandy, : Arch. Surg., 20: 1021, 1930. Cited by Grey Turner, Modern Operative Surgery, Cassel & Co., London, 3rd Ed., 1946, p. 404.
2. Gale, G.: Bilateral Accessory Nerve Paralysis in Surgical Injury. Canad. Med. Assoc. J., 70: 189, 1954.
3. Hanford, J.: Surgical excision of Tuberculous nodes of the neck. Surg. Clin. N. Amer., 13: 301, 1933.
4. Inman, V., Saunders, J. and Abbott, L.: Observations on the function of the shoulder-joint. J. Bone Surg., 26: 1, 1944.
5. Lahey, F.: Radical neck dissection. Surg. Clin. N. Amer., 29: 631, 1949.
6. Lodge, W. and Gueukdjian, S.: Modification de l'opération d'anastomose facio-hypoglosse pour paralysie faciale. Presse Méd., 49: 1025, 1955.
7. Mead, S.: Posterior triangle operation and trapezius palsy. Arch. Surg., 64: 752, 1952.
8. Norden, A.: Peripheral injuries of the spinal accessory nerve. Acta. Chir. Scandinav., 94: 515, 1946.
9. Oppikofer, E.: Über die grundsatzlich chirurgische Behandlung der Halslymphdrusen Tuberkulose. Schweiz. Med. Wschr., 26: 677, 1952.
10. Rade, V.: Poskozeni n. accessori pri probatorni exisi. Prakt. Lekar., 33: 18, 1953.
11. Woodhall, B.: Trapezius paralysis following minor surgical procedures in the posterior cervical triangle. Results following nerve suture. Ann. Surg., 136: 375, 1952.
12. Wulff, H.: The treatment of tuberculous cervical lymphoma. Late results. Acta. Chir. Scandinav., 84: 343, 1941.

Psychology At The Nova Scotia Hospital*

E. G. Nichols, M.Sc., Ph.D.

Psychology, to judge from its popularity in the press and the many magazines that cater to the popular taste for condensed and digested wisdom, offers a veritable panacea in one form or another for people's difficulties or a writer's frantic search for provocative material. Its present status has led the Professor of Psychology at Dalhousie to remark, in a paper on psychology in the University (2), that the popular conception of this subject is of an "admixture of religion, pornography and pseudo-science." Lest our own thinking about the subject be conditioned by such influences it might perhaps be well to give consideration to finding a suitable definition, before proceeding to a discussion of its role within this hospital. With all due respect for those who have had undergraduate psychology courses, I shall take this liberty of assuming the need for greater clarity because of the almost total absence of academic psychology from the medical curriculum at our university.

There is no denying that psychology, whatever it really means, may be construed as harbouring elements of so-called religion, pornography and pseudo-science. The history of psychology, which dates from man's initial efforts to understand himself, bears witness of the many outlandish and bizarre ideas that have obsessed thinkers and writers from time to time. Science, psychology, philosophy and religion however, have, when one surveys the ages of man, only just become differentiated as separate disciplines and areas of study, each too extensive to all be fully understood and held in one cosmology as was the knowledge of the medieval scholar. The aforementioned popular definition would appear then to reflect nothing more than the limited perspective of the uninformed mind. We might leave, for the sake of simplicity, the search for an adequate verbal definition and turn rather to find, if we can, what persons who regard themselves as psychologists are doing. With what do they concern themselves? What is their background? There are a variety of answers to these questions as there are if one asked them of the medical profession. There are even medical psychologists. We find first of all that there is a background of knowledge contained in the many scientific journals and texts on the subject and related subjects with which a student must become familiar. The subject matter relates mainly to the overt and covert behaviour of organisms, particularly but by no means only, to that of the human organism. The theoretical and curious, having finished their studies, and having become familiar with what is already known, may search for answers to new questions, and others will attempt to tell persons what the subject is all about, some become involved in the application of what they have learned to problems in everyday situations—in the school, in business and industry, in hospitals, in almost every conceivable situation nowadays where humans and lower organisms are interacting with others or machine systems. Their methods are most commonly those of science but sometimes it is difficult to be as rigorous or precise as one might like and one leans more heavily on the laws of probability. Occasionally persons may try to classify psychology as a biological science, a social science or some sort of applied study. The student

*Paper given at a recent meeting of the Halifax Medical Society at the Nova Scotia Hospital as part of a program on "Modern Methods of Treatment in the Nova Scotia Hospital."

at one time or another may be troubled by such conflicting views. I do not think we can expect to find any solution to this, this evening.

The Department of Psychology in this hospital has members with a variety of degrees of training and their efforts are, to some extent, defined by the peculiarities of the situation. Problems are presented to the department from the various other departments within the hospital and the majority of these problems arise in connection with patients. The psychologist can utilize a variety of relatively standard and objective situations to compare the patient's behaviour with that of other types of patients or normals whose symptoms and/or progress through hospital are to some extent understood. It can be misleading to refer to intelligence and personality tests in referring to these situations, as the popular conceptions of intelligence and personality are sometimes misleading, but the test situations are most conveniently labeled in this way. It is the thinking of the subject or patient that is of the greatest concern in these test situations and here in the hospital the psychologist actually deals with psychopathology,—pathology of thought as mirrored in speech and other acts and the psychologist functions in the same relation to the other disciplines in the hospital as the pathologist and radiologist do to the other services in the general or other hospital. This investigation of behaviour pathology involves him in face to face interviews that may be limited to an hour or extend over a number of days. The exchanges are for the most part verbal, though they may be written, and the organization of simple objects may also be involved. The ultimate goal is to arrive at some diagnostic-prognostic formulation of the patient's problem. Occasionally the psychologist may be involved in psychotherapy under psychiatric guidance.

A tangential problem to which we have also recently addressed ourselves is that of the schooling of the younger patients—for as their numbers have increased and our facilities and methods of treatment improved, the hospital has been confronted with persons whose educational activities have been interrupted and who, if therapy is to be effective, must learn once more to fit into a school program. This area of child treatment and rehabilitation presents a fascinating challenge and the opportunity to study in detail the behaviour of persons who have many potentialities and whose personalities are still somewhat plastic and more amenable to careful therapeutic management.

The personnel problems presented by a large and widespread staff present still other challenges. It is uneconomical to hire and attempt to train misfits in stenographic, clerical, attendant and nursing positions, and we have attempted to derive some satisfactory norms and selection procedures to deal with these situations.

A portion of the department's time is spent in teaching,—basic psychology, clinical psychology and preparing seminars for various staff or affiliated persons.

Lastly, though in some ways one of the most important, is the department's research activity(1). That is the investigation into various practical problems connected with the day to day routine, the reliability and validity of the various test procedures or aspects of the therapeutic activity of the hospital and ultimately problems and ideas of a more theoretical psychological nature.

Psychology to be of any interest and in this setting of any use, must contain as subject matter evidence or facts and some relationship must obtain between these facts so that when this evidence is considered then meaningful

statements or predictions can be made on the basis of the relationship between samples of the person's behaviour and his later behaviour in a greater variety of situations. The classification of behaviour and the attempts at understanding it constitute the subject matter of psychology and the largely practical application of this knowledge in this hospital setting constitutes the role of clinical psychology.

REFERENCES

1. Nichols, E. G., The Role of Psychology in the Nova Scotia Hospital. Paper read at the opening ceremonies of the Admission Unit of the Nova Scotia Hospital, Dec. 1958. To appear.
2. Page, F. H., Psychology in the University and its contribution to Mental Health. *Bull. Marit. Psychol. Assn.* 1951, May, 3-6.

Abstract

The Results of the Treatment With Tolbutamide of 200 Diabetic Patients: A Discussion of Secondary Failure. Moss, J.M., et al, *Ann. Int. Med.*, 50: 1407-1417 (June), 1959.

The results obtained from using tolbutamide in 200 patients with diabetes are reported in this paper. Forty-nine per cent of the patients obtained a good or excellent result. Seventeen per cent showed no demonstrable benefit from the administration of the drug and 16% had a temporary beneficial effect, followed by a **secondary failure to respond**. The best results were obtained in the asymptomatic older diabetic patients who were of near-normal weight and who required less than 40 units of insulin. Most of the primary and secondary failures were in patients who did not meet these criteria. Five patients had a good response for several months and then developed secondary failure without obvious cause. Because this secondary failure cannot always be predicted, it is important that patients on tolbutamide be followed at intervals of from four to eight weeks after initial stabilization. Six obese patients obtained better results from a placebo than they did from tolbutamide. It would seem that the good results often reported in obese patients are due to reduced caloric intake rather than to tolbutamide. Obese patients should be treated by diet alone, and tolbutamide used only if hyperglycemia persists. Eleven patients went through major surgery and two had normal pregnancies while their diabetes was controlled with tolbutamide. There were no significant toxic effects.

S.J.S.

S.J.S.

The Hemangiomas

Howard I. Goldberg, M.D.
317 Barrington Street
Halifax, N. S.

Although readily recognized clinically, this commonly occurring group of birth marks and new growths frequently present themselves as a therapeutic problem. They may be simply classified as follows:—

1. Flat angioma or nevus flammens or "port wine stain."
2. Cavernous angioma or nevus vasculosus or "strawberry mark."
3. Stellate angioma or nevus craneus or "spider nevus."
4. Senile angioma or "ruby spot."

The port-wine stain is seen at birth, as a well-defined, flat lesion and is usually red to purple in colour. It can occur on any part of the body, but is most commonly seen on the back of the neck. Its size increases correspondingly with the growth of the infant and it can assume a bright red colour when the baby is agitated. This latter effect often alarms the parents.

This hemangiomatous nevus is, composed of mature blood vessels and persists throughout the life span. It is of significance only when appearing on an exposed area and these do unfortunately occur on the face and in this position create a cosmetic problem, because there is no satisfactory treatment available. These lesions are notoriously radio-resistant and therefore must never be treated by X-ray or radium. Some of the more superficially penetrating electro-magnetic emanations e.g. Grenz and Thorium X radiation do succeed in somewhat lightening the lesions. The best advice the physician can give is to recommend the use of a theatrical make-up, e.g. Covermark. Patients can become quite adept in its application and become perfectly acceptable socially.

The so-called strawberry mark nevus is usually seen as a single, raised, red lesion with a smooth, corrugated surface. They can occur on any part of the body and are sometimes multiple. They usually appear at birth or during the first three months, increasing in size until the child is about eight months of age. This lesion is composed of immature blood vessels and the bulk of these lesions disappear by the time the child is five years old without any visible skin defects. Regression often begins as scattered islands of desanguination or as clearing in the center. Some can be composed of deep blood sinuses which impart a bluish shade to the lesion.

Since this lesion is characterized by spontaneous remissions no treatment is necessary. Exceptions to this rule may be the unfortunate site of the lesion e.g. peri-orbital or peri-oral (a monstrous lesion preventing proper feeding of the infant.) Since these lesions are highly radio-sensitive and particularly so in the early months of growth, Gamma radiation (radium) is the method of choice. Parents can be unduly concerned about this type of birth-mark and frequently demand some form of therapy. The application of a dry ice pencil (solid carbon dioxide) with pressure can be safe and produce dramatic results, but not without resulting scarring. Dry ice, as obtained from ice cream manufacturers, may be used and cut and shaped according to the size of the lesion being treated. The Kidde apparatus is a small unit that can be used in the office to make the dry ice. Injection of a lesion with sclerosing agents, e.g., sodium morrhuate is painful and not now widely used.

The spider nevi may occur singly or multiple, and most frequently occur on the face. They are easily recognized by their raised, red, usually pin-head sized central portion with fine tortuous telangiectatic blood vessels radiating from this like the spokes of a wheel. They are of no serious import, but may be a skin manifestation of a rare hereditary systemic disorder. They can be successfully eradicated by electro-desiccation, the insertion of a fine electrolysis needle in the central lesion or in the lumen of each telangiectasia.

Senile angiomas are usually multiple and occur in the middle and advanced age group. They are of no serious import and, as a rule, require no treatment.

Abstract

The Relationship Between Heart Disease and Gall-Bladder Disease.
Hampton, A. G., et al, *Ann. Int. Med.*, 50: 1135-1148 (May), 1959.

The statistical incidence of heart disease and gall-bladder disease is presented and discussed. Some of the literature on the subject is surveyed and evidence is cited to support the view that the gall-bladder may initiate reflexes which help to produce electrocardiographic changes, arrhythmias and an anginal type of pain.

Heart disease and concomitant gall-bladder disease are quite common. An association greater than coincidence is probable. Experimental and clinical evidence has shown that arrhythmias and decreased coronary blood flow may be induced by distention of the biliary tract. Angina pectoris, arrhythmias and electrocardiographic abnormalities may improve after cholecystectomy. Electrocardiographic changes which revert to normal after operation appear to constitute evidence of underlying coronary artery disease. The mortality risk in patients with heart disease and gall-bladder disease is probably under 3%. Elective cholecystectomy is usually well tolerated. Improvement in cardiac status results only from removal of extrinsic stimuli. There is no change in the fundamental intrinsic heart disease.

Thus patients with a history of repeated attacks of cholecystitis who have a nonfunctioning gall-bladder on X-ray should also have a cholecystectomy, for the same reason. Patients with an asymptomatic, nonfunctioning gall-bladder should not have such surgery unless more clinical evidence indicating gall-bladder disease develops.

S.J.S.

Some Neurological Emergencies

Walter Leslie, M.D.

Halifax

The Oxford Dictionary defines the word "Emergency" as a "sudden or unexpected condition." In this sense, one supposes almost any illness could be considered an Emergency. More common usage, especially in the Medical world restricts the meaning considerably and the term is usually applied to a situation in which prompt efficient action must be taken to prevent death or prolonged morbidity. Any attempt to go further than this and to define a medical Emergency as opposed to a surgical one or even further yet and decide which ones properly belong in each of the special fields, is an impossible task, and one is eventually forced back onto custom. The fact is that no such division exists—it is all Emergency treatment and must be based on relatively simple general principles which are common to the whole discipline of medicine. The specialists, surgical or medical enter the picture later.

Other speakers on this program are slated to deal with the Cerebral Vascular Emergencies and Dr. Shane will later speak on Hypertensive Encephalopathy—a much smaller but clear cut entity. So being in somewhat of a quandary as to just where to begin and what to include, I have fallen back on statistics and have dealt with those conditions most commonly admitted as Emergencies to the Neurological Wards of this Hospital (Victoria General). Excluding the Cerebro Vascular accidents per se and Hypertensive Encephalopathy, the largest single group left can be considered under the heading of Convulsions (this includes a fair number of vascular origin).

An isolated convulsion in a child or an adult is not as a rule an Emergency, except to the next of kin. The problem to the physician is largely a diagnostic one, perhaps including reassurance of the alarmed relative. If, however, a convulsion is repeated at intervals, the situation, if these intervals are brief, rapidly becomes serious and has to be dealt with quickly to prevent death or permanent brain damage. The question of diagnosis remains a matter of primary importance but when attacks are recurring in a rapid sequence, consideration may have to be deferred—in such cases it is our practice to give sufficient Sodium Amytol intravenously ($3\frac{1}{2}$ to 5 grains is usually sufficient) to control major convulsions before proceeding with further investigation. I am convinced that no matter what the underlying pathological process may eventually turn out to be this is the preferred procedure. While the injection is being prepared by the nurse or by some other assistant, a rough neurological and physical examination can be done even on a patient in status epilepticus. The breath should be smelled, for evidence of medical or social intoxication, the limbs and head checked for paralytic manifestations or evidence of injury, the pupillary reactions and the fundi examined if at all possible. The collection of specimens of blood, urine and spinal fluid can advantageously be deferred until the patient is quiet. While waiting for Emergency reports on the various specimens, an attempt should be made to obtain an accurate history. Obviously in most cases, this requires the help of a relative, a witness or at least someone other than the patient. Very often, a good history is all that is required to make the diagnosis. Many of these patients are known Epileptics and some-

times known to the hospital staff which is always a help—one should never, however, lose sight of the possibility that on this particular occasion, something else may have happened.

There may have been a head injury, the patient may have ingested some toxic substance, or may be developing some acute illness. Even with a clear history it is not safe to omit the usual routine diagnostic investigation. If no history of this sort is available, one has to inquire into the recent history for evidence of illness or any precipitating factors such as alcohol or other toxic substance, into the past history for signs suggesting cardiac or renal disease or the development of some cerebral irritation such as a brain abscess or tumour. In pregnancy of course, Eclampsia comes readily to mind and is seldom missed. It should not be forgotten that both Encephalitis of viral origin and Encephalopathy of the post Infective variety may be ushered in by a series of convulsions. The same is true of the Meningitides. One should be especially alert in the history to complaints of recent headache which may suggest intracranial pressure, or meningeal irritation and any evidence of focal cerebral disturbance, such as a transient disturbance of behaviour, aberrations of speech and so on. Any or all of these may indicate the development of serious intracranial illness; the significance of such things is often not recognized by the family and has to be asked about directly. In children, it is important to inquire regarding any increase in clumsiness or irritability. At this time too, one should make inquiries regarding the emotional stability or otherwise of the individual and any previous history of disturbances of consciousness. One cannot afford to forget that hysteria may closely mimic status epilepticus and various forms of paralytic disease, so much so that even the skilled observer is often in some doubt. It seldom takes very long to detect the spurious nature of the manifestations, but there are still occasions where the confusion is difficult to dispel. One must also remember that a fractured skull or subdural haematoma may represent either a cause or a result of seizures.

Most of the conditions I have named are easy enough to diagnose and all that is necessary is to keep them in mind. From time to time a more difficult situation arises. The patient shows a delayed return to consciousness for no apparent reason; most commonly this occurs after a series of violent convulsions and is associated with a relatively slow pulse and moderately elevated temperature. There are no signs of localized brain damage—the eye grounds are normal and all other examinations have been noncontributory except in a negative way. Spinal puncture will usually show a moderate increase in pressure, perhaps 300 mms of water. In this case, the patient has almost certainly a so-called "wet brain" and will respond very rapidly to intravenous Dextran, Plasma or about 40 mgms of Urea. All of these are perfectly safe and even if it should eventually turn out that the patient is suffering from a brain tumour or some other form of Encephalopathy no harm will have been done and one will often have produced a lucid period during which valuable information may be obtained.

Occasionally, just to keep us from going stale and discouraged, the diagnostic problem is a much more difficult one. Fortunately it is in these cases that when one does stumble on the correct diagnosis, a most brilliant therapeutic result is often obtained. For example, we had a young girl on the Ward recently who is said to have been well until about two months prior to admission when she had what was diagnosed as pyelonephritis with an elevated blood pressure and characteristic urinary findings. Under appropriate treat-

ment she appeared to make a complete recovery. A month or so later had a slight relapse—a month after that began to complain of severe headaches and within 48 hours had a series of violent convulsions which were difficult to control. Between seizures she was confused and irrational. On admission to the Hospital, her findings in brief were as follows: Blood pressure was 190 systolic, 120 diastolic; fundi were considered to be normal; spinal fluid pressure 250; chemistry in the spinal fluid normal. The urine loaded with albumen with very few casts and no red cells. B.U.N. only moderately elevated. After being in a confused and irrational state for a few hours with several convulsions, she lapsed into a coma with very labored respirations and an obviously embarrassed heart. After being given 40 mgms of Urea intravenously, she almost at once regained consciousness became quite clear mentally and wondered what had been going on. The following day a Retrograde pyelogram was done which showed a hypoplastic kidney on the right side—at least, that was the diagnosis advanced by the Consultant Urologist. Three Rogitine tests were done—two were positive, the last one negative. The value of the test of course was completely negated by the fact that she had been given large quantities of Barbiturates prior to admission. Within a few days her blood pressure started to rise again and she was obviously going to slip back, so it was decided to remove the bad kidney. The result was quite dramatic. As soon as the vein was clamped, the blood pressure dropped to normal, remained normal throughout the removal and continued so throughout the rest of her hospital stay. During this time she showed herself as a happy, intelligent young female who apparently suffered no permanent ill effects, except the loss of one kidney. Admittedly this sort of thing is a rarity but it is what makes life worth while.

Tumours do not too often cause confusion. Very few of these patients actually go into status—they are much more apt to have a Jacksonian type of attack and while consciousness may be clouded for a considerable period after such an attack and there may be moderate confusion, repeated convulsions, except of a focal type are rather rare. Much more commonly, they have one or two generalized seizures from which they appear to be recovering and then suddenly slip back into a confused, retarded, and semi-clouded state without any further convulsive manifestations. Almost always there are evidences of local intracranial disease, though occasionally one may not be able to make the diagnosis without the help of a neuro-surgeon.

Encephalitis as a rule is febrile—not always, but usually. There is often, but again not always, a moderate increase in the number of mononuclear cells in the spinal fluid. The type of Encephalitis we see nowadays is commonly associated with involvement of the cranial nerves of a rather irregular variety—when this feature is missing, one may be in doubt for a considerable time. Many of these patients convulse very violently and may require heavy sedation with Barbiturates for several days and sometimes weeks. We have felt in the last few years that they have a better chance of survival if sedation is combined with a rather massive steroid therapy, this of course being covered by anti-biotics. It is surprising how little residual disability even desperately ill patients frequently turn out to have. Such cases present a challenge to all one's therapeutic skills. No hard and fast rules for their management can be laid down.

When convulsions are associated with a sudden sharp rise in blood pressure, a pheochromocytoma may be suspected but it is a very rare condition

in my experience and the diagnosis is extremely difficult to establish even with the most modern of methods and the combined efforts of a team of experts—we will say no more about it here. Disturbances of glucose metabolism are quite easily diagnosed by routine methods and are seldom a cause of confusion—it is usually a simple matter to find out if the patient has been taking insulin. The presence of an elevated or low blood sugar will give a clue in most cases. Similarly the diagnosis of Uremia or Eclampsia has only to be thought of in order to be made, if that is the condition from which the patient is suffering.

Group 2: The presence of stiff neck and fever with either, clear or moderately clouded consciousness suggests Meningitis or Subarachnoid Haemorrhage. Both of these are readily established by the cerebro-spinal fluid findings and in the case of certain types of Meningitis, one may at times be quite sure beforehand. In the presence of a skin rash of the characteristic variety, and signs of Meningitis, the diagnosis of Meningococemia is almost a certainty. Similarly with a more slowly developing illness of Meningitic type in a patient who has been exposed to Tuberculosis. The Pneumococic and Streptococic varieties may be a little more difficult to establish—the more rare varieties we will not discuss. It is well to bear in mind that Meningococic Meningitis responds to Soludiazine better than it does to any of the anti-biotics, especially when it is given intravenously for the first 48 hours. Streptococic varieties respond better to anti-biotics, though the Sulfonamides are still useful and the Pneumococic variety in particular often does better with a combination of the Sulfonamides and an anti-biotic than with either alone. Tuberculous Meningitis is treated as you all know, with Streptomycin, I.N.H. and perhaps P.A.S. We have discontinued the use of intraventricular medication. If facilities are available, specific sensitivities should always be determined and are a further guide to specific therapy. Brain tumors, abscesses and sub-durals are basically surgical conditions and are treated in that department.

Group 3: contains the acute paralytic diseases, notably Poliomyelitis and Acute Infective Polyneuritis including the so-called Guillain Barre & Landry types. Even the mildest of these are potential Emergencies, which may become acute at any time in the first few days. Involvement of the brain stem (with all its accompaniments of respiratory embarrassment and disturbances of circulation) may occur in all of them. In days gone by one would have included Diphtheritic paralysis here. I suppose one should still think of it but in actual practice it is hardly ever seen. We strongly suspect nowadays that many of the conditions formerly classified as Post-Infective are actually Hypersensitivity reactions to treatment of a previous infection, this is especially true of the anti-biotics and one has to be on the lookout for it. In such cases, steroid therapy is logical. Unfortunately, we have no really specific treatment for any of the conditions in this group, except the Diphtheritic one which we never see any more. The problem basically is that of keeping the patient alive until the acute invasive phase is over and then doing the best one can in the way of rehabilitation. The only feature of these diseases which concerns us here is the management of the respiratory difficulty which is the complication which above all others, means life. It has been our practice to place these patients on a rocking bed at the earliest evidence of any difficulty in breathing and if necessary to give them extra oxygen by the open method. Very often this is all that is necessary. If the difficulty is increasing the patient is placed

in the respirator, at first for short periods then for longer ones as he becomes accustomed to it. Many patients fight the respirator at first and to keep them in it under these circumstances does more harm than good. It is a thing which takes a little bit of learning. Almost always if the respirator is necessary, the patient is much better off with a tracheotomy. This procedure not only simplifies nursing care but gives a much better airway than can be provided by any other method and also furnishes a ready means of dealing with the accumulation of bronchial secretion which is so troublesome. I am convinced that many patients lost in past years could have been saved if this procedure had been more widely used. Certainly, if the blood pressure shows a tendency to rise, it is a must, even if respiration does not appear to be seriously embarrassed. It is surprising how often a steadily rising blood pressure will drop to normal as soon as a tracheotomy is done. The procedure is also valuable because many of these patients are unable to swallow easily and the problem of Aspiration Pneumonia is a serious one if they are fed by mouth.

Group 4: Acute headache and vomiting:—In general diagnostic problem is practically the same as that of convulsions (Idiopathic Epilepsy excluded). The sole difference in management is that since there is no clouding of consciousness or obvious immediate danger to life, more stress is placed on early and accurate diagnosis and less on symptomatic therapy.

Group 5: Contains one lone member and not very many of them. The acute Myasthenic crisis is extremely rare except in known Myasthenic patients and then is not usually any great problem therapeutically. Occasionally one will succumb before adequate therapy can be instituted. The condition may be suspected when one is confronted with a picture of profound muscular weakness and marked bulbar involvement which has come on rather rapidly in a patient with a perfectly clear sensorium and no evidence of any febrile illness, such as Poliomyelitis. For immediate but rather transient relief, we use Tensilon intravenously, Mestinon can also be given intravenously and has a much more prolonged but slower effect and the two are often combined. For a maintenance drug, Neostigmine Methyl Sulphate is still a standby, though there is a newer drug, Mysuran Hydrochloride which perhaps in time may replace it.

In this field a sound therapeutic motto seems to be—"Deal with the threat to life and function first and worry about the minutiae of diagnosis later."

HIGHLIGHTS OF THE CANADIAN DERMATOLOGICAL ASSOCIATION ANNUAL MEETING

Canadian dermatologists assembled for their 13th annual meeting in Montreal early in June, with headquarters at the Queen Elizabeth Hotel. The clinical session and scientific papers were of high calibre, several of them comprehensible to your reporter, and some of the subjects discussed are thought to be of interest to the profession at large.

1. Griseofulvin in the Treatment of Superficial Fungous Diseases

Encouraging reports in British, U. S. and Canadian journals in recent months, of oral treatment of fungous infection of the skin with the antibiotic Griseofulvin have stimulated great interest among dermatologists. The drug, developed and manufactured in Britain, has been used successfully in the treatment of stubborn conditions such as trichophyton rubrum infection of the nails, microsporon audouini and favus of the scalp, and the hyperkeratotic fungous infections of palms and soles. (Griseofulvin will also deal with most of the commoner fungous infections, but the latter usually respond to less expensive measures.)

The necessary dosage, as reported by Dr. Anna Flint, is from four to eight 250 milligram tablets daily, and the more deep-seated conditions such as trichophytosis of the nails may have to be treated for 10-12 weeks. (However, no previous treatment, except X-rays in a few cases, have been found to be of much use for treating "ringworm" of the nails.)

Disadvantages

(a) **Cost.** This drug is manufactured in Britain and the U.S.A., and the retail price is now just under 36 cents per tablet. The cost will presumably eventually drop to a level more in accord with Maritime economy, but for the moment griseofulvin is not likely to be used lavishly. It is to be hoped that it will be available on prescription only, and that it will be prescribed only for proved cases of fungous infection.

(b) **Side Effects.** No important contraindications or undesirable reactions have been reported so far, though some will undoubtedly be discovered with wider use of the drug. (The development of aspermia in experimental rats occurred only when the dosage was twenty times the equivalent therapeutic level. It was even suggested in discussion that a low sperm count might be regarded as desirable by some of our patients!)

(c) **Note to Gynaecologists.** Griseofulvin is ineffective against *Candida Albicans*, so please keep sending your monilial patients to the dermatologists.

2. Fungous Infections of the Scalp.

Dr. Fritz Blank presented the result of a careful survey of rural areas of Quebec, mostly in the Gaspé peninsula, which unearthed a large number of cases of Schoenlini (Favus) infection of the scalp, a condition thought to be rare in Canada. This is apparently spreading along the peninsula, and may well be present in rural New Brunswick or Nova Scotia. Most interesting also was his discovery of several cases of microsporon infection of the scalp of adults—despite what the textbooks say.

3. Total Body Irradiation in the Treatment of Cutaneous Lymphomas.

The disadvantages of conventional X-ray therapy, with its undesirable penetration and systemic side-effects, in the treatment of widespread skin lymphomas (such as leukaemia cutis, mycosis fungoides, Hodgkin's disease of the skin, etc.,) are well known. The use of cathode ray therapy in Boston and at Bethesda has been most helpful, but the number of patients which can be handled by these two machines is small, and the substitution of soft irradiation through beryllium window tubes, reported by Dr. Schirren of Munich, may provide a more readily accessible method of treatment. Dr. Tellner of Montreal described satisfactory palliative results in a number of cases treated in his office, without the development of post-irradiation blood dyscrasias or radiation sickness.

4. Other Activities.

We were given the opportunity to conduct a random sample of Montreal night life, which among other things gave us the privilege of seeing and hearing the wonderful and indestructible Edith Piaf, whose act was a technical masterpiece of projection of her warm personality.

At another educational centre a young woman provided a remarkable exhibition of auto-organic convulsions, terminating in exposure of 92% of her impressive anatomy (allowing 5% for the shoes).

These and other amenities (liquid, solid, and ethereal) provided by the local committee, were much enjoyed by the visiting seekers-after-knowledge, and the Queen Elizabeth Hotel seemed to your reporter to be the ideal setting for a large scale city convention, providing comfort and personal attention to a degree which was surprising in such a large structure.

D.R.S.H.

Experimental Hyphema. Sinsky, R. M. and Krichesky, A. B. American Journal Ophthalmology, 48: 2-215, August 1959.

In spite of the relatively common occurrence of hyphema (blood in anterior chamber) in practice there is very little agreement in ophthalmic literature as to the course of therapy. Severe visual impairment, even enucleation of the eye is sometimes necessary following complications from hyphemas. Most authors agree on bandaging the eyes and bed rest but, as to the use of mydriatics or miotics there is practically no concurrence.

The authors using rabbits and radioactive tracers (Cr^{51}) determined hyphemas are absorbed most rapidly in the first two to three hours, and that mydriatics (atropine, neosynephrine) or miotics (eserine, DFP) statistically do not show an increase or decrease in the rate of absorption of the hyphema.

J. H. Q.

Notes on Maritime Medical Care, Incorporated

Nova Scotia doctors have an excellent opportunity now to assist in the enrolment campaign of Maritime Medical Care, according to D. D. Chapman, sales manager of that corporation.

Now that the recommended review of the activities of Maritime Medical Care has been completed, and certain changes instituted, including the adoption of the 1958 schedule of fees of The Medical Society of Nova Scotia, he said recently, "we sincerely request more complete cooperation from participating doctors."

Recently, he went on, every participating doctor in the province with the exception of those in Halifax and Sydney were asked to send in lists of their patients and their addresses who might qualify for participation in M. M. C.'s Individual Plan. This plan is for those under sixty years of age who are self-employed or who work in a place with fewer than five employees. Applicants, unlike those for the Comprehensive Plan, must complete a medical questionnaire.

Fewer than a dozen physicians took time out to send in lists, however, and the Sales Office of M. M. C. would like to receive many more such lists as soon as possible. Those prospects are approached exclusively through the mails with literature and details concerning the Individual Plan.

It is thought that the patient's family physician would best know those among his patients who should have such coverage and that far better results would be experienced than from a "blind canvass".

"Our chief competition continues to come from commercial companies selling group health and accident coverage," Mr. Chapman says in his statement. "While we do not object to competition from this source we feel very strongly that such competition can be met only if participating doctors make certain that subscribers under such commercial protection be charged the full fee schedule of The Medical Society of Nova Scotia by their doctors and that where the insurance company pays only an indemnified amount toward the fee the subscribers be informed of this and billed for the difference."

Maritime Medical Care has approximately 125,000 members and nearly nine hundred groups ranging in size from five to thousands.

"We have sold many of these groups," said Mr. Chapman, "as a direct result of a doctor, or doctors, recommending the coverage to employees. Indeed, ever since the plan was formed by The Medical Society of Nova Scotia back in 1949, it has been my firm conviction that the best M. M. C. salesman could be the participating doctor. Up to the present, the statement that this is "the only Plan in Nova Scotia sponsored by The Medical Society of Nova Scotia" has an all too hollow ring. Maritime Medical Care offers to the people of Nova Scotia prepaid medical care unequalled by any commercial plan. The support of this plan by the medical profession insures its continued growth."

Personal Interest

LOCAL NOTES

Cumberland Medical Society:

June 17, 1959: Summer meeting at Ottawa House, Parrsboro followed by a lobster supper for members and wives. Guest speaker was the manager of the new salt mine at Pugwash, Mr. John MacQuarrie, who spoke on "Salt in Cumberland County."

Dr. and Mrs. Hugh Christie spent two months this summer touring Europe and the United Kingdom.

Dr. Norman Glen and family spent a month visiting relatives in Scotland and England.

Western Nova Scotia Medical Society:

Dr. Anthony Scott, a graduate of Dublin University has recently become associated with Dr. W. C. O'Brien, Yarmouth, N. S. Dr. Scott practised for three years in England following which he served in the Far East with the R.A.F. and more recently practised briefly in Newfoundland. He is married and has one child.

Dr. and Mrs. Milton O'Brien, and Dr. and Mrs. W. C. O'Brien of Yarmouth, N. S. are visiting in Montreal.

Dr. Robert Belliveau of Meteghan was a successful tuna fisherman recently.

Dr. J. Balmanno and his father, both fishing from the same boat, hooked tuna simultaneously and the former passed his rod and fish to another boat to enable his father to make a successful landing.

Dr. F. Melanson, Yarmouth and Dr. P. H. LeBlanc of Little Brook are attending a Refresher Course in Quebec.

Mrs. (Dr.) D. F. Macdonald was called home due to the illness and subsequent death of her father, Mr. J. O. Root of Brown City, Michigan.

University:

Dr. Walter C. MacKenzie, a Dalhousie Medical School graduate, (class of '33) has recently assumed his duties as Dean of the Medical School, University of Alberta.

Obituary

Dr. William Edward Gallie, 77, eminent Toronto surgeon, died in the Princess Margaret Hospital, Toronto, September 25, 1959. As Professor of Surgery at the University of Toronto in 1929, he inaugurated the first co-ordinated program for the training of young surgeons in Canada. The subsequent success of the Gallie Course and the positions of eminence attained by those who took it has and will affect the standards of training of surgeons in Canada, and to some extent the United States, for half a century. A local medical journal is hardly the place to outline his life, his personal achievements, or his honors. Suffice it to say—here died one of the true greats of Canadian medicine.

Dr. Clarence MacLean Miller, 79, an honorary member of The Medical Society of Nova Scotia (1953), an outstanding Pictou county citizen, died in New Glasgow September 18, 1959. Born in Stellarton, Medical Graduate from McGill (1904), practised in Stellarton until after World War I, post-graduate work at London and Edinburgh in 1920, fellow of Royal College of Surgeons, Mayor of New Glasgow during the difficult depression years. "He excelled in every phase of life, to which he gave his time and talents."

COMING MEETINGS

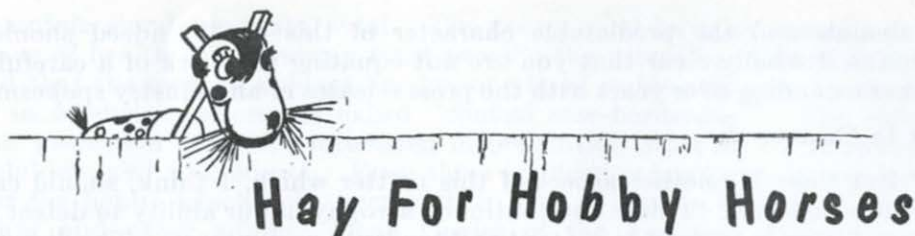
October 26-29, 1959—Annual Dalhousie Refresher Course—Victoria General Hospital.

October 30-31, 1959—Royal College of Physicians and Surgeons of Canada—Atlantic Regional Meeting—Victoria General Hospital.

November 4, 1959 —Halifax Medical Society—First Regular Meeting—Victoria General Hospital.

FOR RENT

Offices of Doctor H. R. Peel, Truro, Nova Scotia. Centrally located on ground floor and adequately heated. Available with or without his equipment. Immediate occupancy. Apply to—The Acadia Trust Company, Truro, Nova Scotia.



The Decline of Righteous Indignation

In a letter to the Editor of the New York Times (August 19, 1959), J. K. Galbraith of Harvard reminds us that we accommodate ourselves to all manner of nonsense, deception and calculated public disservice without a murmur.

Here is the letter for those of my readers who are concerned with such matters:

"On August 7th you published a report on the findings of Dr. Harold F. Dorn, a Government research scientist, on the relation of smoking to the death rate. The study, according to your account, covered nearly 200,000 veterans whose smoking habits had been ascertained before their death. It found that the death rate for heavy cigarette smokers was about twice that for non-smokers. The incidence of lung cancer, an important and usually mortal affliction, was sixteen times as great for heavy smokers as for non-smokers.

"The auspices under which the study was conducted, the United States Government, commands respect. The sample of 200,000 men suggests the formidable scale of the enterprise. Few would wish to challenge the bearing of the conclusions on an important problem of the public health. If from some wholly improbable sampling bias the figure for lung cancer were twice too high, an incidence eight times as great for heavy smokers would be impressive.

"Your news story, nonetheless, carried several paragraphs of a statement by Timothy V. Hartnett, the head of something called the Tobacco Industry Research Committee, which said it wasn't so. The findings, he said, were unsupported by "clinical and experimental evidence," an observation which would rule out all conclusions based on statistical inference or even common observations which we use daily.

Unsupported Evidence

"His complaint could be used with equal effect against our present belief that the earth moves at regular intervals in a given orbit around the sun. There has been no clinical or experimental evidence to support this view. You also quote Mr. Hartnett as saying that unnamed statisticians have challenged the conclusions in unspecified ways. Unspecified objections of unnamed scholars do not command great confidence.

"There are two matters in connection with this episode on which I would urge reflection. In the news story, while you give considerably more space to Dr. Dorn than to Mr. Hartnett, you treat the statements of both with equal respect. Does not this seeming impartiality mean, in fact, that you are allowing Mr. Hartnett to use you for his own purposes in a rather outrageous way?

"For years now the tobacco industry has been capping careful research reports with these unsupported denials. I certainly wouldn't suggest that you suppress Mr. Hartnett but shouldn't you remind your readers of these

past denials and the predictable character of this one? Indeed shouldn't you make it wholly clear that you are not equating the work of a careful researcher extending over years with the press releases of an industry spokesman?

Link to Cancer

"But there is another aspect of this matter which, I think, should cause even more concern. This is the continued atrophy of our ability to detect and our unwillingness to react to blatant and tendentious nonsense. The discovery that heavy smoking causes cancer is, no doubt, a serious threat to numerous interests, of which the tobacco companies are the most prominent.

"Once Americans had an inspired nose for such special interest and a gifted ear for special pleading. They also had a most rewarding reaction. Mr. Hartnett's contentions would have been met by raucous charges of bias and special pleading. He would have been proclaimed the most suspect of all possible witnesses. Perhaps he would have advised his principals that discreet silence was far wiser than a seeming desire to make a dollar out of propelling the customer to a premature and painful death which nature prefaces with a period under sentence that cannot be greatly more agreeable, except in the quality of the mattresses, than waiting in the death house for the rope.

"But now dimmer perceptions, or incapacity for indignation, or perhaps mere indifference, means there is no reaction of any kind."

The spectacle of two tobacco companies spending 180 millions in three years to enlist juveniles in a habit which "propels the customer to a premature and painful death" arouses no response from the average physician. Dr. Galbraith has hit upon an excellent example of our incapacity for indignation but there are many others. For example, we are concerned with ways and means to improve the mortality rate of patients who have myocardial infarction characterized by the development of shock. The mortality rate is in excess of 80 per cent. We debate the use of vasopressors v. the Trendelenberg position and a "lytic" cocktail, and urge the addition of hypothermia and the availability of a "defibrillator." Would we ever sit down with the same sense of urgency to plan ways and means of bringing back the Spartan virtues of disciplined appetites, regular exercise and mental attitudes that would delay vascular deterioration? I am not depreciating the efforts of physicians to improve the treatment of this common catastrophe, but in all disease where treatment is relatively ineffective prevention becomes an urgent necessity. This is true even when methods of prevention rest upon an insecure hypothesis. Witness our massive efforts to prevent poliomyelitis by prophylaxis with gamma globulin ten years ago. Substantial prevention of inhalation carcinoma awaits only the consent and concern of the smoking public. Surely the sight of senior physicians chain-smoking through a panel discussion on carcinoma of the lung must make the Devil rub his hands in glee.

Enough on this popular means of "relaxation and pleasure." There are many more illustrations of our ability to see the mote and miss the beam. The profession is not much concerned with the prevention of traffic deaths, the support and reinforcement of efforts to improve our system of education, the provision of a religious basis for the lives of our children. The physician has duties as a parent and a citizen as well. I have the impression that my father's generation accepted much greater responsibility for their example to their children and to the world than does mine. The old dictum "it just isn't done" is sneered at now, but the willingness of the responsible members of our society

to maintain standards is still vital. The young must have an example and in matters of health the physician must provide the example, at least in public. I find that the medical student has become fixed in his attitudes by his third year in Medicine—a process called “clinical case-hardening.” The segment of our profession primarily interested in prevention must fix its attention on the children and adolescents. Even these youngsters have already contracted either the habits which will shorten their lives or have a bias to them from parents and other adults. Dean Davies of the American Cancer Society recently wrote to me as follows:—“What action do you think would be indicated if it is discovered that, let us say, 70 per cent of the smokers are addicted to nicotine in a pharmacologic manner? To me, education of teen-agers about the hazards of cigarette smoking is only the beginning. We have estimated that if the current increase in lung cancer continues at its present rate, there will have been some three and a half million lung cancer deaths before the present teen-agers reach the lung cancer peak when they are 60. At that time (2,000 A.D.) there will be about 140,000 lung cancer deaths a year in this country alone. The problem is, I believe, the most serious and challenging one in cancer to-day.”

This is a tormenting and baffling problem but it pales into insignificance beside the spectre of atomic extermination. Lewis Mumford writing in the current issue of the *Atlantic Monthly* begins “The Morals of Extermination” in these words:—“Since 1945, the American government has devoted the better part of our national energies to preparations for wholesale human extermination. This curious enterprise has been disguised as a scientifically sound method of ensuring world peace and national security, but it has obviously failed at every point on both counts. Our reckless experimental explosion of nuclear weapons is only a persuasive salesman’s sample of what a nuclear war would produce, but even this has already done significant damage to the human race. With poetic justice, the earliest victims of our experiments toward genocide—sharing honours with the South Pacific islanders and the Japanese fishermen—have been our own children, and even more, our children’s prospective children.” This article should be read and prayed over in every home in the nation. Our dilemma is summed up in this box score of the atomic age.

Strontium 90 Humanity 0

Yours sincerely,

BROTHER TIMOTHY

Erratum

Lines 5 and 6 of “A Flavoring of Characters” (*Nova Scotia Medical Bulletin*, September, 1959, page 363) should have read—“We can reach early agreement on the desirability and value of **character**. All education has for its object the formation of character.”

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of July, 1959

Diseases	NOVA SCOTIA				CANADA	
	1959		1958		1959	1958
	C	D	C	D	C	C
Brucellosis (Undulant fever) (044)	0	0	0	0	10	0
Diarrhoea of newborn, epidemic (764)	0	0	0	0	4	0
Diphtheria (055)	0	0	0	0	0	2
Dysentery:						
(a) Amoebic (046)	0	0	0	0	0	0
(b) Bacillary (045)	0	0	0	0	34	0
(c) Unspecified (048)	0	0	0	0	21	0
Encephalitis, infectious (082.0)	0	0	0	0	4	2
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	0	0	0	0	0	0
(b) Salmonella infections (042.1)	0	0	0	0	0	0
(c) Unspecified (049.2)	0	0	0	0	85	0
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	4	1	34	0	189	0
Meningitis, viral or aseptic (080.2, 082.1)						
(a) due to polio virus	0	0	0	0	0	0
(b) due to Coxsackie virus	0	0	0	0	0	0
(c) due to ECHO virus	0	0	0	0	0	0
(d) other and unspecified	0	0	0	0	16	0
Meningococcal infections (057)	0	0	2	0	7	29
Pemphigus neonatorum (impetigo of the newborn) (766)	0	0	0	0	5	0
Pertussis (Whooping Cough) (056)	3	0	107	0	289	548
Poliomyelitis, paralytic (080.0, 080.1)	0	0	0	0	59	40
Scarlet Fever & Streptococcal Sore Throat (050, 051)	101	0	105	0	792	243
Tuberculosis						
(a) Pulmonary (001, 002)	20	2	30	5	396	467
(b) Other and unspecified (003-019)	3	3	4	0	98	45
Typhoid and Paratyphoid Fever (040, 041)	1	1	0	0	29	45
Veneral diseases						
(a) Gonorrhoea —						
Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	44	0	15	0	1022	138
(b) Syphilis —						
Acquired—ordinary (021.0, 021.1)	0	0	0	0	0	0
— secondary (021.2, 021.3)	0	0	0	0	0	0
— latent (028)	0	0	0	0	0	0
— tertiary — cardiovascular (023)	0	0	0	0	0	0
— „ — neurosyphilis (024, 026)	0	0	0	0	0	0
— „ — other (027)	0	0	0	0	0	0
Prenatal—congenital (020)	0	0	0	0	0	0
Other and unspecified (029)	0	0	5*	0	173*	1218*
(c) Chancroid (036)	0	0	0	0	0	0
(d) Granuloma inguinale (038)	0	0	0	0	0	0
(e) Lymphogranuloma venereum (037)	0	0	0	0	0	0
Rare Diseases:						
Anthrax (062)	0	0	0	0	0	0
Botulism (049.1)	0	0	0	0	0	0
Cholera (043)	0	0	0	0	0	0
Leprosy (060)	0	0	0	0	0	0
Malaria (110-117)	0	0	0	0	0	0
Plague (058)	0	0	0	0	0	0
Psittacosis & ornithosis (096.2)	0	0	0	0	0	0
Rabies in Man (094)	0	0	0	0	0	0
Relapsing fever, louse-borne (071.0)	0	0	0	0	0	0
Rickettsial infections:						
(a) Typhus, louse-borne (100)	0	0	0	0	0	0
(b) Rocky Mountain spotted fever (104 part)	0	0	0	0	0	0
(c) Q-Fever (108 part)	0	0	0	0	0	0
(d) Other & unspecified (101-108)	0	0	0	0	0	0
Smallpox (084)	0	0	0	0	0	0
Tetanus (061)	2	0	0	0	0	0
Trichinosis (128)	0	0	0	0	0	0
Tularaemia (059)	0	0	0	0	0	0
Yellow Fever (091)	0	0	0	0	0	0
N.S.U.	3	0	0	0	0	0

C — Cases D — Deaths

*Not Broken Down

Remarks:

During the month of July, two cases of tetanus occurred in the Cape Breton area in boys whose ages were 10 and 11 years. Both children were very ill and both received tetanus antitoxin. Neither child had ever received tetanus toxoid.

The following is a summary of the poliomyelitis situation in Canada to August 15, 1959. This information is taken from "Surveillance Report of Epidemic or Unusual Communicable Diseases" reports which are distributed to the provinces by the Department of National Health and Welfare and is compiled from reports which the provinces send to that Department:

PARALYTIC POLIOMYELITIS

Canada

For the weeks 29th to 32nd (July 18-August 15) the number of paralytic poliomyelitis cases reported in 1959, represented the highest figures registered for these weeks since 1953. The only other year, when these figures were exceeded, was 1949.

The cumulative total for 1959 to week 32nd is 329. In the last ten years this total has been exceeded only in 1949 and 1953.

The figures for weeks 29th to 32nd and the cumulative totals, to this date, for the past ten years are presented below—

Year	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959
Week 29	17	9	16	24	85	25	11	8	4	3	29
Week 30	65	13	37	35	135	26	44	5	8	3	45
Week 31	122	16	45	64	183	42	23	7	5	3	87
Week 32	92	24	82	93	256	53	43	12	3	9	103
Cumulative Total	371	115	233	298	875	324	208	85	64	55	329

The 103 paralytic cases reported in the 32nd week is the highest figure for any week since 1953.

In the last ten years the peak week has ranged from the 33rd to the 38th week. Below are the weekly totals for the peak weeks from 1949 to 1958—

Year	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958
Peak Week	33	33	34	35	38	37	35	36	38	38
Weekly Total	218	28	113	112	301	102	45	26	16	255

It would appear that in the last ten years there has been a shifting of the peak week from the middle of August towards the middle of September.

This year there has been increased reporting of paralytic poliomyelitis cases from five provinces, Newfoundland, New Brunswick, Quebec, Ontario and Saskatchewan.

The age distribution and vaccination status of the cases reported in Newfoundland were presented last week in the Surveillance Report.

Detailed reports have been now received from Quebec and Ontario.

Quebec

The cumulative total for 1959 now stands at 219 paralytic poliomyelitis cases, being the highest total reported to date, in the Province of Quebec, for the last ten years. The 88 paralytic cases for the current week is the highest weekly figure reported in the Province since 1959.

The highest concentration of cases is to be found in the city of Montreal, the surrounding metropolitan area and within a fifty-mile radius of Montreal. In the rest of the Province only sporadic cases have occurred.

Ninety-four per cent of cases have occurred among the unvaccinated. The highest incidence is to be found in the 0-9 age group, 65 per cent. Most of the adult cases have occurred in Montreal and the metropolitan area, 16 per cent of the local total, while in the rest of the Province the adults represent only 5 per cent of cases.

A high incidence of bulbar cases has been noted, 23 per cent. Only one of the bulbar cases was vaccinated. This is a triply vaccinated case and agammaglobulinemia is suspected.

Among the 13 deaths reported to August 12th, none were vaccinated.

With the exception of two Type 3 virus, all other polio virus isolated were of Type I.

The age distribution of the paralytic poliomyelitis cases and deaths, to August 12th, including vaccination status and bulbar cases is presented—

Paralytic Poliomyelitis, Quebec, to August 12, 1959

Age Group	Total Cases	Vaccination Status					Bulbar	Deaths
		0	1	2	3	4		
0-4	48	46		1	1		4	4
5-9	55	49	1	2	2	1	14	1
10-14	25	23	2				9	3
15-19	12	12					3	2
20 †	19	19					7	3
TOTALS	159	149	3	3	3	1	37	13

SOURCE: Doctor Adelard Groulx, Director, Department of Health, City of Montreal; Dr. Gustave Charest, Epidemiologist, Department of Health, City of Montreal; Division of Epidemiology, Department of Health, Quebec.

Ontario

The 1959 cumulative total now stands at 31, being the highest to this date, since 1955.

Below the paralytic poliomyelitis cases and deaths to August 15th, by age group and vaccination status is presented—

Paralytic Poliomyelitis, Ontario, to August 15, 1959

Age Group	Total Cases	Vaccination Status					Deaths
		0	1	2	3	N/K	
0-4	13	6	1	1	3	2	
5-9	7	5	1	1			
10-14							
15-19							
20 †	11	9				2	3
TOTALS	31	20	2	2	3	4	3

SOURCE: Dr. R. P. Hardman, Epidemiologist, Department of Health, Ontario.

Abstract

Effects of Periodic Mental Stress on Serum Cholesterol Levels.
Grundy, S. M. and Griffin, A. C. *Circulation*, 19: 496-498 (April) 1959.

During recent years many factors have been found that apparently influence the development of atherosclerosis. Factors such as diet, sex, hormonal imbalance, heredity, and exercise are among those being studied most extensively at the present time. There are several recent reports suggesting the possible role of emotional stress as still another factor in atherogenesis and in coronary disease.

In this paper further studies on the effects of periodic mental stress on serum cholesterol levels have been carried out on a large group of medical students.

The effects of quarterly final examinations on serum cholesterol levels in two large groups of freshman medical students were studied. During the two periods of examinations studied the mean cholesterol levels were elevated significantly over control periods of relative relaxation. The two groups of 50 and 47 male students showed a 16.5 per cent and 11 per cent increase in serum cholesterol levels during winter and spring quarter examinations, respectively.

L. C. S.

Abstract

Common-Bile-Duct Stones. Bentley P. Colcock, M.D. and Harold V. Liddle, M.D., Boston. *New England Journal of Medicine*, 258: 264-268, (Feb.) 1958.

The Records of 100 consecutive patients who had an exploration of the common duct at the Lahey Clinic from October 1949 to December, 1952 are reviewed. Pain was the most dependable finding and it occurred in 95 patients. This pain was typically a recurrent colicky pain in the right upper quadrant or epigastrium with frequent extension to the back and subscapular area. It was so consistently present that it was used as a major criterion in the follow-up study. Any patient who had this symptom was considered to have a residual common-duct stone. Jaundice or a history of jaundice was found in only 43 of the 100 patients. Jaundice is frequently absent when common-duct stones are present. Six patients had light stools in the absence of jaundice. Chills and fever occurred in 50 patients. At operation, 87 patients had a dilated common-duct. Thirty-two of the ducts contained a single stone and 68 contained multiple stones.

Ninety-four patients had a follow-up period of four to six years. Two of these 94 patients (2.12 per cent) required a second choledochostomy for retained common-duct stones.

This study did not include patients who may have had retained common-duct stones after cholecystectomy alone or retained common-duct stones after cholecystectomy with a negative choledochostomy. As Smith et al have pointed out, however, the problem of retained stones is primarily related to the patient who has or has had stones in the common bile duct. They reported 0.8 per cent retained stones after cholecystectomy alone, and 1 per cent after common-duct exploration when stones were not found. When stones had been previously removed from the common bile duct, they found retained stones in 11 per cent.

Operative cholangiography was not used in these patients. A careful surgical exploration still constitutes a dependable method of detecting common-duct stones.

J. O. G.