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The NOVA SCOTIA MEDICAL BULLETIN

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Editorial

Medical Education

It has become almost as popular for our profession to discuss Medical Education as it has for our children to discuss The Beatles - perhaps our emotional response is less vivid but in any hospital lounge it is possible to stir up a pretty lively controversy by dropping the trigger-word.

Outside the university itself, the conversation revolves around "They" - "They" are apparently that myopic group of specialists, interested in research and esoteric diseases, who use students as data collectors or audiences for intricate monologues - "They" do not understand country practice, "They" know nothing about making critical decisions without all the scientific paraphernalia and how would "They" like to treat the coronaries, the pneumonias, the croupy children in the home? Consequently "They" are totally unable to prepare the student for the realities of medical practice.

On the other hand, in the university the clinical teacher despairs for his student group. They just don't seem to realize the importance of his subject - How can they ever expect to go into practice and avoid all the erroneous ways of their predecessors - The answer must be more time for **this** subject, more staff, more beds, more lab space.

But the basic science teacher - ah, this is the real doctor. He gives the student a marvelous understanding of all the essential disciplines. How beautifully the enzymes of oxidation play their roles, how simple is diabetes mellitus in terms of calories and insulin, how apparent is the hypertension explained by the tumor seen in the post-mortem room! How can the student forget so quickly and the practitioners know so little of these "facts"?

How can our various groups make common cause and take serious thought for the problems in Medical Education. In this BULLETIN and in the local press we have recently had considerable discussion of the question. Glib solutions are as frequent as they are impractical. It may well be that major changes must be made, that old concepts must be questioned and the whole citadel of tradition brought into question. But there will be no place for ill-conceived schemes. The subject with which we deal is far too important to risk any approach which cannot without doubt insure reasonable success. Accepting this premise, we must nevertheless come to grips with changing situations.

Changes in the social structure of our society, the rapid increase in one body of knowledge and its constant change, advances in techniques and equipment, the changing role of the allied professions; all these have tended to break up the medical profession into subgroupings which are becoming increasingly

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remote from each other. Even worse, there does not appear to be a firm centre to which we all can hold.

Is it possible today to prepare a young man or woman to practice medicine without prior knowledge of the type of medicine in which he will engage. Is it good enough to call the brand-new M.D. a "General Practitioner" and turn him loose, when we require 4 more years to qualify in a restricted field? We hear talk of enhancing the stature of the family doctor. How are we doing this?

Experience in general practice today offers **no** help in the program leading to specialist qualification. A man with 10 years of experience has to start on equal terms with yesterday's graduate. Hasn't he learned anything? Can the Medical School really decrease this course and that course and still produce a safe product? Should the program be radically altered so as to teach only the basic sciences, their human applications, and leave the bulk of clinical experience to a post-graduate development, including one leading to qualification for general practice?

We hear talk of shortening the medical course - Where? Can we drop the pre-medical years? Have they served their purpose in training candidates in the humanities or science? Do the courses prescribed make any sense in relation to life or practice?

The more one investigates the whole matter, the more one opens up new questions.

At the present time a Committee of the Faculty of Medicine at Dalhousie is studying these questions with a view to preparing a major report which will suggest ways to update our system of Medical Education to meet current needs. It behooves all those who are concerned about the practice and future of medicine to **write down** their ideas and communicate them to this committee. Everyone's ideas, worries, and suggestions should be heard. If we have special regional problems in the Atlantic area, they may call for special measures. Undoubtedly there are problems aplenty. These can only be defined and appropriate solutions worked out if the **whole** profession does some solid thinking and forms clear ideas. Let us be vocal, and let our voices be heard in the right places.

S.C.R. ■

DOCTORS OPPORTUNITY

Tenants moving into the new Medical-Dental Building at the Davisville subway are vacating smaller offices, all sizes which you can sublet at reasonable rates, all offers presented. Also some spaces available in the new Medical-Dental Building. Write Vern Campbell, H. Keith Ltd., Realtor, 181 Eglinton Ave. East, Toronto 12, Ontario.

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Dr. Harry S. Smith

AN APPRECIATION

Dr. Harry S. Smith of South Brookfield, died on July 28th, 1964; he was born in South Brookfield, Queens County, son of the late Mr. and Mrs. S. Primrose Smith. He obtained his high school education in Caledonia.

He graduated from Acadia University in May, 1928, at the age of 20, with a B.A. degree and what is now equivalent to a B.Ed. He then taught at The School for the Blind, where he translated one of the textbooks into Braille after first learning this language himself. From here, he went to Pictou where he taught for one year. Following that, he entered McGill University, studying medicine, graduating in 1936. He served one year internship at The Saint John General Hospital. His first practice was in Mill Village with his uncle Dr. Freeman Smith. At the end of the year he returned to his home that he loved in South Brookfield, and took over the practice of Dr. Albert (Allie) MacLeod, in Caledonia.

Soon, with Dr. Smith's support and encouragement, The North Queens Cottage Hospital was developed and has served the community well for many years. Through his repeated intercessions he was able to enlist the support of the Provincial Government to improve steadily this institution. It is unfortunate that he did not live to see the fruition of his efforts in the new Hospital that is soon to be constructed in Caledonia.

He was also a member of the staff of Dawson Memorial Hospital and Queen's General Hospital.

In 1942 he married Freda Irving, R.N., of South Brookfield. They have two sons, Andrew Duncan, age 15 and Lawrence Michael, age 12.

Harry was a scholar and his reading carried into many fields of thought. His library is filled with books of the finest in English literature. History stirred in him a particular interest. His modesty would permit him but infrequently to speak at larger gatherings; yet, those, who heard him, still remember these learned lectures, interspersed with history and philosophical deductions. He loved nature in all its forms - the flowers, the trees, the streams. Among his hobbies was searching in the hinterland for indications of old Indian settlements. In his home there is a museum where will be found many of the rarest documents that many a collector would be proud to possess.

He was an exceptionally fine conversationalist, possessing a rare gift of story telling with which he would hold an intimate audience for hours.

As a clinician he was brilliant, keenly interested in all his patients. In him we recognized a strong character, a person of great integrity and one endowed with a fine sense of humor. As a friend and medical associate, he will be sorely missed. Those who knew him well admired and loved him more than he ever knew.

In the home we saw a kind, intelligent, good and loving father. It is with regret that we must realize that his two fine sons will be denied the further fellowship and instruction that Harry would have provided for them. Our deepest sympathy goes to them and to his devoted wife, who so faithfully stood by him over the years.

Dr. Harry S. Smith was truly a great man, and these two Counties in particular, and the Province in general, have been enriched by his presence, and are the poorer by his untimely death.

It was good to have known him.

J.C.W.

Health Services in Canada

ADDRESS DELIVERED AT THE

111th ANNUAL MEETING

of the

MEDICAL SOCIETY OF NOVA SCOTIA

By

THE HONOURABLE JUDY LAMARSH*

I am very happy indeed that I was able to accept your kind invitation to be with you this evening.

You have chosen a very picturesque setting in which to hold your meetings, and I am sure that these pleasant surroundings will be very conducive to constructive deliberation.

I note that you are the oldest Medical Society in Canada, having been founded in 1854, ten years before the Fathers of Confederation sat down together at Charlottetown.

Your seniority among Canadian medical societies must be a source of great pride and satisfaction.

I propose to talk to you tonight about a subject which is of very current and immediate concern to all of us - the Report of the Royal Commission on Health Service.

You will recall that it was the task of this Commission to take a long and hard look at Health Services in Canada, and report upon existing facilities and the future needs of all Canadians in this field.

The resources to provide these services were to be assessed, and recommendations made as to what measures the Commissioner thought necessary to ensure the best possible health care for all Canadians.

The Commission was set up at the request of the Canadian Medical Association, so all members had a very direct interest in it right from the outset.

The basic approach is the development and maintenance of Health Services on a planned and coordinated basis, and making the most effective use of the Nation's health resources.

The recommendations which the Commission has made form a broad framework for the overall development of comprehensive health services for all residents of Canada.

We have already had a very successful experience in Federal-Provincial cooperation through the Hospital Insurance program and the National Health Grants, and the Commission recommends that the pattern already established be extended.

However, to be realistic, we must recognize that the Commission's recommendations are very complex and have far-reaching financial implications.

Very careful consideration must therefore be given to all its recommendations before any definite policy proposals are put forward by the Federal Government.

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*Minister of National Health and Welfare.

But I can assure you that the planned and coordinated approach to health services and the prepayment principles of financing them, are fully endorsed by the government and, I think, by the vast majority of Canadians.

These principles were really recognized as far back as 1948 when the Health Grant program was established.

At that time, the then Prime Minister announced that one of the primary objectives of the program was "to lay the foundation for a comprehensive health insurance program."

This was again evidenced in 1957 by the Hospital Insurance and Diagnostic Services Act.

In introducing that legislation, the then Minister of National Health and Welfare, my present Colleague, Paul Martin, emphasized that "the government was motivated by the same considerations which the Prime Minister had enunciated in 1948."

This is still our policy.

Indeed, if you will permit me, I should like to quote now from a pamphlet on health care which was given wide distribution by the Liberal Party during the last election campaign. It read in part:

> "Standards of health care" in most of Canada are high. But many Canadian families do not benefit as they should. Prepaid care is not available to everyone, on terms everyone can afford. Many people stay away from the doctor or do not take prescribed treatments because they fear the cost.
>
> Others are forced, by the expense of serious illness, into crippling debts.
>
> This is not good enough. All Canadians should be able to get health care at the time they need it, without the anxious fear of bills they cannot afford.
>
> Liberal policy is designed:
>
> To wipe out the fear of heavy medical bills.
>
> "To attract more people into medical practice and research so that better service can be provided to all."

So you see, the present Government is very well aware of the commitments it has made on the subject of health care. We intend to live up to those commitments.

That is why we are devoting such urgent attention to the Hall Report.

As I said in the House last Thursday, some 14 Committees in my Department are even now examining the Commission's recommendations.

I repeated at that time that we hoped to submit the position of the Federal Government in this respect to a Federal-Provincial Conference early in 1965.

In short, we propose to push ahead as fast as sound planning and responsible leadership will allow us.

I might say here that there are a number of recommendations in the Report which have especially caught my eye.

I am sure, for instance, that all of us are more than a little concerned over the resources and facilities at our disposal to cope with mental illness - certainly one of the most pressing and challenging problems confronting Canadian health authorities today.

(In this regard, incidentally, I am not unmindful of the fact that Nova Scotia is the most advanced of our provinces in the provision of community mental health services. This is indeed a proud record.)

To get back to the Hall Report, I was particularly interested in its recommendations concerning integration of mental hospitals under our Hospital Insurance Program. I personally feel this is long overdue.

As you may know, we are holding two important conferences on mental health in Ottawa next month.

The first, opening on October 19th will deal with mental retardation and will be attended by some 150 experts in the field - including representatives of the Federal and Provincial governments as well as from a number of private voluntary agencies.

We are counting on this Conference to produce some firm proposals which will lead to greatly improved provisions for the retarded in Canada.

Our intentions in this area, incidentally, draw an interesting parallel with similar programs in the United States, so notably stimulated and encouraged by the late President Kennedy.

The second Conference will be held in Ottawa October 26th. At this one, our Federal and Provincial experts will examine the means by which Canadian mental hospitals can be brought into the Hospital Insurance program.

Before going on, I might say here that I was most interested to note the remarks made by your own Society in the brief which you submitted to the Commission.

You said, and I quote, "the Hospital Insurance and Diagnostic Services Program has operated exceedingly well and problems have not been as great as were expected."

You went on to say, and again I quote, that "results have been good and many Nova Scotians have been relieved of great insecurity from great hospital bills."

Such comments are most encouraging and I would hasten to add that they are possible largely as a result of the active support and cooperation of the medical profession.

A moment ago I mentioned that the Royal Commission endorsed the principles on which the Hospital Insurance and Diagnostic Services program is based.

Important among these principles are provincial operation and administration, federal sharing in costs, provision of comprehensive services of high quality to all residents on uniform terms and conditions, portability of benefits and the maintenance and enhancement of free, independent, self-governing professions.

We also believe that these principles are fundamental to the development of health services. I realize, though, that your profession is not in full agreement on all of these features especially those relating to medical services insurance.

In the successful development of health programs, governments and the health profession each have an essential role to play. Let me say a few words now about the role of governments.

The Report urges a continuation of the present role of the Federal Government, but proposes further developments which will have to be worked out with the provinces.

As you know, the provinces have a great deal of legislative jurisdiction in the health field and the Federal Government has always emphasized the cooperative approach.

The Federal Government is urged to provide very substantial assistance in the training of health personnel and the provision of facilities for training and research.

I think everyone here will agree that *this* is where the heaviest stress must be placed as time goes on.

All of us who are close to the health picture in Canada are only too well aware of the critical shortages we are facing - both of manpower and in facilities.

Personally, I do not think many of us can be too happy about the continuing exodus of so much of our most promising medical talent to other countries.

Something must be done to keep it here where it is so badly needed.

I think in this respect that we must provide better opportunities for training, for research and for service to those who need it.

If we are suffering from a shortage of doctors *now*, I hardly think the situation will be made any less critical when we ultimately introduce a national program of medical care.

Surely, this is one thing we must keep in mind at all levels of government, as well as in the health professions themselves.

As far as the Government in Ottawa is concerned, we are ready and eager to do whatever is possible - under our constitutional responsibilities - toward this end.

I am sure that most of you are aware that we recently made **$4,000,000** available to assist in the construction of a Health Sciences Center at the University of British Columbia.

This is no doubt one of the most ambitious projects of its kind ever undertaken in Canada, and my Department is viewing it as a pilot project.

Here on the east coast, although the Department of National Health and Welfare is not so far immediately involved, I was pleased to hear the other day that the National Centennial Commission is going to contribute two-and-a-half million dollars from its own appropriations toward the construction of a similar health sciences center at Dalhousie University.

I am informed this represents roughly half the projected cost of the center, and I can think of no worthier centennial project anywhere in this country.

Once we have more such institutions we will be better able to provide the incentives to bring our bright young Canadians into the medical profession and, even more important, to keep them here in Canada.

As you are all aware, education is an exclusively provincial jurisdiction. And so, largely, is health.

About all we can do in Ottawa is to offer our assistance where it will do the most good. This we have done, are doing, and will continue to do - as generously, enthusiastically, and effectively as we can.

As far as the Hall Report itself is concerned, by far the most important proposals are those dealing with medical services benefits.

The universal availability of comprehensive personal medical services - preventive, diagnostic, curative, and rehabilitative, - on uniform terms and conditions is the basic goal.

I know that all of the recommendations do not coincide in every respect with the expressed opinions of the medical profession.

However, I am convinced that most of these difficulties can be resolved through negotiations and willingness to cooperate.

During the Medical Association's meeting in Vancouver last June, the President conveyed to the Prime Minister the Association's pledge of its best

(continued on page 324)

Some Observations on the Prospects for Medical Insurance Services in Nova Scotia

ADDRESS DELIVERED

BY

THE HONOURABLE R. A. DONAHOE*

Probably no topic of more current interest than that of Health Services or what this Society thinking in the context of your own profession has called "Physicians Services Insurance."

Your Society has made a careful study of the entire matter and related it to your own Research Committee's estimates of Nova Scotia's needs and circumstances and has put its conclusions before the Government almost one year ago.

Since then the Government has moved to appoint its own Advisory Committee under the Chairmanship of Mr. Frank Rowe, Q.C., and this Committee has been functioning steadily on an information gathering basis up until recently. A week or two ago the Committee has announced that it is more prepared to receive submissions and opinions from all interested persons and groups. I trust that the medical profession will not overlook this Committee as it is capable of providing still another avenue by which the views of that profession may influence the decisions which Government may eventually take.

Despite all the consideration that is being given across the country to this vitally important subject perhaps it is fair to say that governments have been inclined to mark time pending the submission earlier this year of the Hall Commission Report on Health Services. Now we have this Report or at least what purports to be its first massive volume. The consideration is continuing but now focussed in the light of the Commission's specific recommendations. These recommendations are sufficiently broad and all embracing that they have almost terrifying implications for the medical profession, the related professions and for government alike.

This is not the appropriate occasion to embark upon any analysis of that report even if my knowledge and understanding of it had yet reached the point where I could attempt one which I hasten to say it has not.

In the consideration of this report however, two principles will be constantly in the forefront of our minds. (1) the preservation of the highest degree of the integrity of the medical profession and (2) and overriding every other consideration the provision of the highest possible standard of health care for all our people.

It is probably easier to determine what the standard of services should be than to be sure that such a standard is feasible of attainment and financially within the reach of the people, the government or both.

Planning in this Province will to a large extent not really begin to crystallize until we are made aware of the proposed extent of participation in the cost of any plan by the Federal authority.

This is a point of view that has already been communicated to the Federal Government and no doubt in due course the decisions of that body will be made available to us.

The financing of the plan will be obviously one of the major fields of difficulty for government.

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*Minister of Public Health for Nova Scotia.

Whatever may be the ultimate outcome, one thing is sure: the ultimate success of any plan will depend upon the availability of a sufficient number of qualified personnel in the medical and all related professions. This is bound to impose a demand for more and more in the way of educational facilities and any expansion of these is going to call for more and more persons to be available for teaching and training purposes. The Government of Nova Scotia has already indicated to the Federal Government that here is a field in which it could embark on massive programs of assistance without delay. You cannot have more doctors, dentists, druggists, and technicians without more professors and instructors. No matter what plan is evolved, or even if none ever was evolved, the services of our people under any system requires larger and even larger numbers of professionally trained people.

In Nova Scotia the grant of $2,500,000 allocated for centennial observance will be matched by the Province and at its suggestion, with the approval of the Federal Authority, this money will go to provide some of the now medical training facilities so necessary to us. Further help in this field to promote more training of persons to engage in medical teaching will in the long run ensure the best use of our facilities and the means of providing as early as possible the persons required to give the maximum possible level of health services to all our people.

When Hospital Insurance came the medical profession had misgivings. It is now five years old and I think that it is a rare individual who shares those early fears.

Working in the same spirit with the same regard for each others rights, duties and responsibilities, I am sure that in good time government and the medical profession will evolve a mutually acceptable technique which will redound to the benefit of our people by providing not only the most but the best of all health services required. ■

FROM THE BULLETIN OF 40 YEARS AGO

The Legacy of the Celt

Address by Dr. G. H. Murphy, Halifax, N. S.

The early Irish, like the Greeks, had their great mythical physicians, of whom the most distinguished was Dedannan or Dranket. The name means great power, and the stories of his skill were like those of some of the old Greek mythical physicians. He is mentioned in some of the old Irish Glosses and Incantations for health. He was regarded as a god belonging to a very remote period of antiquity. He had a son, Midach, and a daughter, Airmeda, of whom it is told in one of the old tales, that they became so skilful in treating disease that they aroused their father's envy with the result that he slew Midach. After a time there grew from the young's physican's grave 365 herbs from the 365 joints, and sinews and members of the body, each herb with mighty virtue to cure diseases of the part it grew from. His sister Airmeda, recognized the miraculous significance of the herbs, plucked and sorted them in her mantle. But the jealous old Dranket discovered them and mixed them all up so that their source and application was lost; and hence all the failures of physicians since that time had their source in the mad envy of one old man, who could not bear to be overshadowed by the superior professional skill of a rival.

Parataxis In Medicine

By Dr. Frank Turnbull, Vancouver*

This discourse is about Parataxis in Medicine. Those who prefer plain Anglo-Saxon words will object that 'parataxis' is just another example of tortured Greek, which must be admitted. Parataxis is the habit of discouraging the discussion of questions to which one does not know the answer. This is a convenient policy for some occasions, but is apt to become a chronic course of action. Special problems develop when it is practiced by groups, and in this setting the word parataxis applies. To illustrate that the medical profession has its share of paratactic sloth, I will open Pandora's box and select a few examples.

The Cost of Medical Care and the Doctor

Almost every aspect of medical care seems to have become an object of public interest, but above all the cost. The cost is rising, for reasons which we do not hesitate to explain. It may be a tiresome subject, but we cannot accept the message of the sirens who say that the doctors' only job is to supply knowledge and skill. Some responsibility for cost has to be shared by the doctor, on behalf of his patient as well as for himself. Indeed, our new position has become painfully obvious. If we are not prepared to seek and to justify adequate pay for doing our job we can be certain that our pay will become quite inadequate. We may be called upon to observe the other side of the coin and explain what we do for the money received. The old chestnut about "the priceless value of the surgeon's delicate hands and the metaphorical question "how much is a life worth?", have lost most of their force today, when master craftsmen fashion machines that land on the moon and jet pilots make split-second decisions that spell safety or death for their plane-load of passengers. We have come to accept, after much debate and hard work, that our fee-schedule requires regular revision, with not only a relation of item to item but also a recognition of its total effect. There is another question which we sometimes tackle, but usually allow to dangle. Can doctors do anything to curb the rising costs?

The average Canadian is never far away from insolvency, in spite of what the optimists describe as our buoyant economy. The prospect of uncontrollable expense due to illness, though this is a rare occurrence, can be a genuine source of anxiety to many people. It is a fire that can be easily fanned by those who oppose the present system of medical economics. Hence the furore about Medicare. The citizen is in a quandary. Like Mrs. Ramsbotham, whose young Albert was eaten by the lion, he thinks that 'Someone ought to be summoned, surely someone's to blame'. Who else but the doctor?

How well is the structure that we established to meet the rising costs of medical care standing up to the strain of time? When Pre-Paid plans were introduced in the thirties there was a lot of talk about the importance of coping with the costs of unexpected medical catastrophe. The new method of payment seemed to admirably suited to meet the costs of accidents and serious

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*President, The Canadian Medical Association 1964-65.

acute illness, and experience has vindicated this prediction. There was less thought about the costs of minor illness and serious chronic illness, and how these costs might erode even the strongest plan. No thought at all was given to prepayment for the prevention of illness. During the past two decades we have witnessed the great development and wide acceptance of all-inclusive prepayment plans. We have also noted, with increasing concern, the problems of overutilization by patients and overservicing by doctors. There is now a growing conviction within our Association that these faults of an otherwise good system can only be corrected by arranging to have the patient pay directly some portion of the fee.

The new instrumentation of medical care and the modern requirements of collaboration and team-work have increased the cost and at the same time, paradoxically, have reduced the prestige of the doctor. Individualists are becoming anomalies in Medicine. The doctor's influence on the medical scene is being continuously diluted by a proliferation of non-medical scientists at one end of the spectrum and technicians unlimited at the other end. Some of our cynical colleagues have pointed out that it may appear very altruistic to blindly encourage the dilution of our labour, but this attitude is, in fact, a legacy of days when there was little concern about rising costs. The potential expansion of the "Health Team" is only limited by the amount of money that is available. Nobody is in a better position to indicate when the brakes should be applied than the doctor.

Along with all of the current pressures to create new hospitals, the public and the politicians as well, are being conditioned to accept the high initial costs of hospitals but are not taught to understand their continuing needs. In the average hospital it is only a stroke of good fortune when the supply of medical equipment catches up with routine requirements. It might be good policy to open most new general hospitals with nothing more than a skeleton of medical equipment. This would cause anguished cries, though the trustees would appreciate at the outset that capital expenditure for medical equipment is not a lifetime legacy that is given to the hospital at birth, but an annual transfusion that is essential for growth and survival. The doctors would understand that they had to build gradually according to their special capabilities. The advance of technology today is so rapid that much of the special equipment in hospitals is obsolete after five years. The medical and technical staff have to be organized so that the new equipment will be used to its full capacity. If annual budgets were aimed more deliberately to develop clinical facilities the doctors would settle for fewer of the trimmings in hospital construction and reconstruction.

The rising cost of medical care cannot be expressed in a simple formula. Even the statistical experts acknowledge that their estimates are subject to many pitfalls and broad errors. We do not need the help of precise figures to recognize areas of the problem that can be influenced by the doctors. I have mentioned three of these areas very briefly - the need for ensuring that patients have some measure of personal responsibility, recognition by the doctor of the increasing costs of ancillary services, and the place for better orientation of hospital budgets.

Whatever Happened to Florence N?

Another set of questions which seems to have been pushed under the carpet relates to the working partnership between doctors and nurses. The only obvious link that remains of our traditional relationship is the continuing

frequency of matrimony between junior nurses and internes. It must be admitted that doctors in practice and the more senior nurses have drawn further apart. This is partly explained by the exigencies of economics. The doctor no longer sponsors their employment as private nurses, nor ratifies their final account. Nurses, at least in British Columbia, have displayed a realistic attitude toward payment for their services, including the implied right to strike. However we may regard this new aspect of self-reliance, they have at least not hesitated to experiment in the new fields of arbitration and negotiation, where so far the doctors have hardly wet their feet.

In the early thirties the Canadian Medical Association cooperated with the Canadian Nurses Association to sponsor a National Survey of conditions in hospital schools of nursing and of working conditions of nurses. That report initiated many improvements in the standard of nursing education and the conditions of nursing service. Some of the problems that were discussed in the 1932 Report are still unsettled.*

In the meantime our lines of communication with the nurses' organizations have withered from disuse. If you should be skeptical of that observation consider the First Recommendation of the Canadian Nurse's Association to the recent Royal Commission on Health Services, that "a clear differentiation be made between nursing and medical services and that transfer of activities be made only after study and agreement of all concerned". We must have study and agreement about this inter-professional problem. How did we ever get so far apart? The late Fred Allen used to describe how his dear old parents sat by their fireside holding hands, day after day. 'of course' he added, 'if they had ever let go there would have been hell to pay'. We would do our patients and ourselves a favor if we listened to the thought-provoking questions that are being raised by the modern nurse in our midst, not only at National levels, but also in the Divisions and local hospitals.

An Apple A Day

Some of the questions that keep dodging out to taunt us from the lay press, and from our own medical literature, center around the scope of Preventive Medicine. This area of practice has come to be adopted as a sort of foster-child of Public Health. The feature of Preventive Medicine that I wish to question, is the assumption that it all falls naturally into the realm of public authority, and can be clearly distinguished from curative medicine.

When prevention is considered as an activity of private practice the discussion usually concerns the merits of 'periodic health examination'. Doctors in practice are influenced by their experiences with individual patients. They are skeptical of the value of periodic health examinations, if not for their patients, at least for themselves. A couple of decades ago we acquiesced when these examinations were ruled out of the benefits of the Pre-Paid Insurance schemes. Perhaps that was only practical economics. We should not fail to notice the trend toward mass surveys and to consider their implications. The surveys of the chest and the programs for the detection of cancer of the cervix are well-established and of proven value. Surveys for glaucoma and for the detection of hearing loss in very young children are in the course of development. Surveys for the detection of early disease are just beginning,

(*e.g., the organization and financing of nursing education, and standardization of various programs of nursing education.)

and there is plenty of room for imaginative planning. Many of these surveys can be conducted by the family doctor, particularly doctors who work in groups. The value of records for clinical research in hospital is well established, but the possibility of research through well-organized records of home and office practice is hardly recognized.

The doctor in general practice usually deals with his patients one by one. Unless he perceives a new responsibility to his patients as a group some other authority will usurp his role. Preventive Medicine needs a new point of view, and it could come from the family doctor.

Pyramid or Troika

The final question that needs to be taken out of the bottom drawer concerns the direction and control of hospitals. In a recent issue of CANADIAN HOSPITAL there were two leading articles on this subject. Both were written by graduates of our leading Canadian School of Hospital Administration. They dealt chiefly with the role of the administrator. One was entitled 'Management Development in Hospitals', and the other, 'Who is the Boss?' To say that both of these articles revealed more about the writer than the subject would not be impudent, because they were expressing their personal views. The same subject treated by an experienced hospital trustee, or by a doctor, while also revealing their idiosyncracies, would reveal two other points of view.

Before deciding what makes hospitals run it is necessary to enquire what they are designed to do, and what is expected of them. There appears to be a trend in this country for the modern hospital to become the health center of the community. Hospitals are not going out of their way to seek this new status, nor is the doctor pressing to have the epicenter of medical care moved away from his office. But as the trend develops the hospital expands, and the doctor moves his office closer.

Hospitals are neither 'hotels for the sick' or 'workshops for the doctor', but institutions designed to serve the community by providing the means for patient-care. High quality of patient-care costs plenty of money and higher quality costs more money. Neither the value of the care or the price-factor can be subjected to the precise methods of control that can be used in industry. A good hospital has only one principle - a constant endeavor to achieve excellence.

This complex structure is motivated and guided by three principal forces - the trustees, the administrator, and the doctors. The trustees cannot express the will of the community and plan future development without the expert technical knowledge of the administrator and the advice of a medical staff that they respect. The administrator cannot coordinate the activities of the hospital without the full support of the trustees and a clear channel of communication with the doctors. The doctors cannot achieve high standard of medical care without trustees who are inspired to develop a better hospital, and an administrator who genuinely likes to work with doctors. When Mr. Khruschchev popularized the Russian word 'troika' he had no thought of its application to the hospital scene. Nor is it likely that the word could be used in conjunction with the hospitals of Soviet Russia. But for the situation in Canada today a tripartite view of hospital direction and control seems to be the logical answer to my last question.

(continued on page 323)

Presidential Address

Keltic, September 16, 1964

DR. C. L. GOSSE

Halifax, N. S.

Honored Guests, Ladies and Gentlemen:

The By-laws of The Medical Society of Nova Scotia decrees that on this occasion, the President shall deliver a presidential address. This I now propose to do.

The past year has been marked by considerable excitement and varying amounts of turbulence and agitation. The executive meetings were characterized by drama and even melodrama, and semantics found a new home. Some of the branch societies revived the spirit of the old west, so all in all I am certain our Society is in a very healthy state.

We tried to operate in a democratic way, realizing that "democracy was never designed for efficiency, but was created to give people a say in their own affairs." However, the mills of democracy grind as slowly as the mills of the gods, and I leave the office of President tonight with much unfinished business on the table.

Certain events however might be recounted. The Society presented its brief to government on its health insurance plan. With the help of a $20,000 Federal Research Grant it established a committee under Dr. Alan Morton to "determine the unmet needs of the population of Nova Scotia regarding the distribution of physicians and facilities" - another instance where this Medical Society has led the way in the interest of public welfare. A new fee schedule came into existence. Your Executive fought hard for its adoption by our prepayment plan but eventually made a compromise, which, to say the least, was not entirely popular.

One of the most significant events was the release of the Hall Commission Report. It fell suddenly, as if by design, into the laps of the council of the C.M.A. at the annual meeting in Vancouver. It surprised us all by its socialistic outlook, and while it agrees with many of the traditional principles and current beliefs of the medical profession, it contains some recommendations which, if quality medical care is to be maintained, can not be accepted.

It has, however, many sound and well-designed proposals, proposals which strike at the very heart of the problems of both the public and the profession; at the same time it completely overlooks some of the more urgent and serious ones. For example it suggests ways and means to increase the supply of certain types of specialists, yet fails to suggest any specific means to provide the people with a doctor to call when they are sick.

It does recognize the fact that medical education is still an apprenticeship system, where practising doctors teach doctors how to practise, and recommends that remuneration for part-time teachers be increased to realistic levels.

The report states that the commission is opposed to state medicine, but goes on virtually to recommend it, stating that personal medical services for all should be a social responsibility provided by the state.

It proposes that the traditional individual freedom of the doctor to practise as his mind and heart and soul dictate, the freedom that enticed him into medicine in the first place, the freedom that allows him to protect the quality of medical care according to his own judgment and the judgment of his confrères, the freedom that keeps him working after most people have gone to sleep, that this freedom be subject to and dependent upon the good will of the government of the day.

It expresses views on professional controls which, are against the views of this profession and here I quote from an apt editorial in the Halifax Chronicle-Herald over two years ago which states "Doctors cannot be legislated into existence, nor can a scalpel be forced upon unwilling hands." Let it be known to any government or to any other group who tries to force its will against the best interest of quality medical care, that medicine is and intends to remain, the master in its own house.

The report goes on to recommend that public funds be used to provide health services for all Canadians on a universal and compulsory basis. In Nova Scotia however, this Society has repeatedly expressed the view that those who can afford to pay their way should do so, that tax money should be used to assist those who are unable to meet the complete cost of medical care, and that the government in partnership with the medical profession should combine and cooperate to give quality care to the indigent. It was Abraham Lincoln who once said, "It is the function of governments to do for the people only what they cannot do for themselves, or cannot do so well." The question arises therefore: How much can or should the Government of Nova Scotia do for its people, and how much may we expect the people of Nova Scotia to do for themselves?

We are fortunate in this province that we have the calibre of men in government who I believe want to protect the quality of medical care, and we have been assured that any system which may be introduced will be acceptable to those who provide the service as well as to those who receive it.

At this moment however, the province is seriously **short of doctors**, particularly in the field of family practice. Unless we increase the number of graduates **immediately**, this shortage will soon become critical and any medicare scheme unworkable. **The main effort**, therefore, of the Government, the University and the Profession should be directed to the solution of this vital problem.

To accomplish this the need for more buildings, more facilities, more teachers and therefore more money, is obvious. However, I would suggest that an immediate increase in the supply of doctors in Canada could be achieved by a more business-like and effective use of existing university facilities, and by a fearless reappraisal of teaching aims and methods.

This would involve three major changes.

1. **Year-round operation of the Medical School.** This has been done in some American universities, with favourable results. In 1959, 30 per cent of freshmen entering the University of Pittsburgh indicated that the year-round calendar was an important reason for their selecting that university. In 1960, this number increased to 50 per cent. The suggestion that the long summer vacation is necessary to **earn money** or to **develop maturity** has been refuted. Moneywise the student does not fare badly. He will cut one-third of his time from university, and "what's lost upon the roundabouts we pulls up on the swings." As to the development of maturity, Dr. Grayson Kirk, President

of Columbia University, says, "Students in summer continue to work at strong-back jobs that contribute nothing to their intellectual development, or waste the vacation on activities that prolong adolescence rather than promote maturity." Our own Doctor Kirkconnell, Past President of Acadia, said "Students. . . . . . .return in autumn with nothing learned and much of their earlier course work forgotten."

It has been shown that such a program of year-round operation need not increase the cost to the university; in fact, one medical school found the increase in additional fees more than offset the additional expenditure required for staff and overhead.

Our own Medical School may say that its fees are not high enough to offset the added cost, and more money will have to be found. Assuming this to be true, money is usually available if the need is sufficiently great. The Hall Commission recommends a $2000 annual grant to medical students, and if the Government wishes a medicare plan, then the priority of **more doctors more quickly**, will have to be recognized. To say that such a plan is not possible costwise can no longer be a valid objection. The resources of the Government are infinite - they are as deep as your pocket and mine.

2. The second point is the **scheduling of two medical classes to run concurrently** and thus double the number of graduates. This would be a simple and even more effective solution. You who have passed through the classrooms and laboratories of universities know that space and facilities are for the most part used less than half-time. True, this is not so obvious at Dalhousie as it used to be, nor so apparent as in some other universities. Nevertheless, with the addition of the new Medical Building, the operation of two classes by staggering the use of classrooms and laboratories should be a natural step. **Then**, provided there were enough applicants for Medicine, the shortage could be relieved within a decade. The head of the Department of Education of the University of New Brunswick recently said, "Canadian university faculties are extremely conservative in educational matters. This attitude would have to be broken down before any speed-up in the undergraduate program would be possible." It is interesting to note that a dean in at least one Canadian University states, "There is indication that universities in general are preparing to take a more radical view of their position. Certainly, he says, we have come to the place where heterogeneity in pattern and form is more valuable than dreary uniformity."

3. The **third** essential is the **shortening of the basic medical course.** This is a must if we are to pave the way for special training of general practitioners, the maintainence of the standard of general practice, and the prestige of the family physician. It appears that because of the recent and continuing explosion of scientific knowledge the pre-medical, pre-clinical and even the clinical years are cluttered up with details that are soon forgotten and often outdated before graduation. Dr. Vaughan of Oxford, England, speaking in Boston last June was highly critical of "The tendency to add everything new and subtract nothing old from what the student must know."

If it is recognized, and it must be, that doctors should continue to educate themselves throughout their medical life, should not the primary emphasis in our teaching program closely approximate the motto of the Association of American Medical Colleges, namely "To help the student establish habits of continuing self-education?"

Dr. R. V. Christie, Dean of Medicine at McGill recently wrote of the necessity to get rid of the dead wood, and said: "The minutiae of anatomy, which even the surgeons do not remember, are surely a waste of the ability to memorize facts. Physiology, biochemistry and pharmacology, as they pertain to medicine, could also do with some pruning. Medicine itself is certainly not beyond reproach. Partly because many clinical teachers are consultants, we often **over** emphasize the detailed pattern of uncommon diseases and **under** emphasize the mechanisms involved in disease." "What really matters is what the student remembers and **thinks** after he has graduated."

To effect such changes may not be easy. It will be difficult to convince the professor of physiology or anatomy or biochemistry that adequate teaching in his subject might be done in half the time and probably half of that by clinicians interested in a particular field, such as the central nervous system, the pulmonary system or the kidney. It would be hard to convince the Department of Surgery that much of the teaching it attempts should be reserved for the post-graduate years. It might be nearly impossible to cajole the psychiatrists not to brainwash medical students daily through a whole medical course, and it might be even more difficult to dissuade the Department of Medicine from impressing the student with all the new and unusual laboratory procedures, and that the amount of copper in the patient's blood stream is almost as important as his M.M.C. card.

Oh no! ladies and gentlemen, such radical changes will not come easily. They will challenge the ingenuity, the broad-mindedness, and the bold imagination of all of us. We shall have to turn from the slow evolutionary process of medical education to crash programs of new and outright **innovations.** Some fifty years ago Johns Hopkins University broke from tradition and came forth with a new and vastly different educational system. It was an innovation of revolutionary proportions. As Abraham Flexner, a researcher in medical education, said, "so complete was its success that within two decades its own graduates reproduce the system in many American institutions of learning." Thus a single generation of forward looking physicians displaced with one stroke the ordinary evolutionary growth that might otherwise have required a century or more.

It is easy to say that things move more quickly today, than half a century ago, but we can take advantage of visions only when we seize the occasion, and the occasion is now. As Brutus said

> There is a tide in the affairs of men,
> Which taken at the floods, leads on to fortune,
> Omitted, all the voyage of their life
> Is bound in shallows and in miseries;
> On such a full sea are we now afloat;
> And we must take the current when it serves
> Or lose our ventures.

Ladies and Gentlemen:

The year-round operation of medical schools,
The concurrent operation of two classes of medicine, and
The shortening of the basic course of medical training

or any combination of these, all are within our reach. **Thereby**, the supply of doctors could be doubled within a very few years. **Then**, and only then, universal comprehehsive medical care would be possible, without any deterioration in the quality of care.

Another and very pressing problem is how to **attract more students to the family practice of medicine.** Surveys have shown that a high percentage of students entering medical school have as their goal this type of practice. By graduation day, only a small and diminishing number are so inclined.

Contrary to the opinions of Mr. Justice Hall and his colleagues, the basis of a successful medicare program is not primarily the need for more radiologists, psychiatrists, or eye specialists, or indeed specialists of any kind. Assistants on a technical level could well relieve some specialists of much time consuming details and leave them free for more consulting, teaching or other highly specialized work. Furthermore the swing of the pendulum towards specialization is sufficient to look after this for many years to come. The vital problem is to produce doctors who will see and treat sick people.

Many studies have documented the decline of physicians in general practice. Of the last graduating class at Dalhousie, only six doctors entered family practice in Nova Scotia, and last year twice that many were lost by death or by leaving general practice for some other field of medicine. In Halifax alone, six active general practitioners left to take salaried positions or to enter specialty training. To date these have not been replaced.

It has been shown that most specialists make their choice to so train in the later years of medical school or during their internship. This would appear to coincide with the gradual but obvious changes in teaching programs, - and as a university professor and your President for the next few minutes, I would pose a few questions for your consideration.

A few years ago students were taught by teachers who were spending much of their time in family practice, doing in some instances specialist work as well. Most of us remember men of the calibre of Drs. K. A. MacKenzie, J. R. Corston, H. K. MacDonald, G. H. Murphy, F. G. Mack, and more recently, Drs. J. W. MacIntosh, J. W. Reid, and C. W. Holland whom we have honoured tonight, and many others too numerous to mention. All of these men made house calls. All treated patients as families in their home environment. Students looked up to these men and tried to emulate them, and went out into practice to do so. The practice of medicine and the treating of patients in relation to their family and their environment, the recognition of the interplay between science and behaviour, the realization of the need for prevention and control, the broader view of treatment requirements and community health problems, and the possibilities for out-of-hospital rehabilitation came more easily to these men. They were able to portray to students this natural and respected way of practising good clinical medicine, and they were able to inject into these students a feeling of integrity, and a good dose of the milk of human kindness. I feel fortunate that the background and upbringing in my own home has enabled me to appreciate this so readily.

Many of our teachers today rarely see a patient in the home, and some not often in the office. Most seem to have a special interest in some particular organ and pour out to the student details of rare diseases associated with these, along with stirring accounts of research in that particular field. The trend towards research-orientated teachers is increasing - a situation which I suggest is not compatible with undergraduate teaching; yet it has become the gauge of proficiency by university deans and department heads; in other words, the hallmark of a university professor. One must seriously question whether such teachers can exhibit or display sufficient enthusiasm, or have such background as can interest a student in the family practice of medicine.

I am not suggesting that research is not a vital and necessary part of any science or profession. The value of research **of course** cannot be under-estimated. The search for new knowledge must be pursued with increasing vigor. Without research, medicine would be a trade rather than a profession. Without it many illnesses whose cure is now routine and simple, would still be at the stage depicted by the picture, so well known to all of us, of the kindly and bearded family doctor, sitting disconsolate in his helplessness, by the bed of a sick child. However, as Dr. J. W. Reid, a university teacher, in his Presidential address to this Society in 1953 warned us, take heed "lest the tender care of the sick be wrecked on the hard, unsympathetic rocks of research." Is it not natural for a research orientated teacher to influence his students in a direction that is not conducive to the active practice of medicine?

At a recent meeting of the International Conference of General Practice, it was stated: "It is becoming apparent that in most of our medical schools during recent years, there has been a breakdown in the mechanism by which a close relationship is maintained with community needs and with the community practice of medicine. There has been a steady decline in the amount of teaching by the physician whose main interest is in clinical practice, and he is being replaced by full-time research and hospital-orientated faculty members, many of whom have had little clinical experience." All this would seem to suggest that the universities have lost contact with the practising profession, and specific questions such as these are taking form: "Is the undergraduate medical education program improperly balanced and hence adversely affecting the supply of family physicians?" "Are university programs really designed to meet the needs of our present-day medical practitioners, and the needs of the community in which they serve?" Can the conception of "the patient as a whole" be instilled into students by teachers who are primarily accustomed to thinking mainly of one organ?

Some years ago, deans and department heads of universities were accused of living in ivory towers. The question is now being asked if they have left even those and ascended into the clouds. That may well be a good place to perform some important functions, but my question is: What is being done in their absence about the training of men upon whom the afflicted may call when they need a family physician? Is the gradual depletion of these physicians among our graduates because, either by accident or design, students have been slanted towards the celestial heights of their teachers?

Is this trend, seen in so many universities and so strongly criticized, to be found in our own School? Recently the Chairman of our Curriculum Committee at Dalhousie noted that the full-time teacher-student ratio between 1954 and 1963 more than doubled, and he further stated **that this trend should be considered in planning** The full-time head of one of our major departments doubted if part-time teachers could spare more of their time, and felt that **probably more full-time teachers** would have to be appointed. I suggest that part-time teachers would be available if a section of the Hall Commission report were implemented which recommends that they be adequately recompensed for their loss of time from private practice.

One full-time professor was recently quoted as saying that he is aiming at five full-time teachers in his department. (Even though the Hall Commission **did not see fit to so recommend**) The material cost of this to the University in both money and space can well be imagined, and while you are about it think of the cost in family doctors; or if you would think positively, think of

what could be accomplished by taking the money involved and paying it to part-time practising teachers.

A commentary by Coles in his book, A Young Phychiatrist Looks at His Profession: "For the individual psychiatrist, the institutional rigidities affect his thoughts and attitudes, taint his words and feelings, and thereby his ability to teach and treat patients. . . . I see Organization Men in psychiatry, with all the problems of deathlike conformity." Is this typical of what can happen or is happening in many hospital-confined specialties?

I am **not denying** the need for full-time university professors in administrative and research capacities. Johns Hopkins advocated this fifty years ago. Such are indeed desirable and necessary, (as I have already indicated,) but the present tendency to more and more full-time clinical teachers, to the exclusion of the part-time practitioner-teacher, I submit, is contrary to the interests of family practice, or practice of any kind, and is being loudly criticized by the practising profession across the land.

Furthermore, the greater use of selected general practitioners in certain aspects of the teaching program, and the expansion of the concept of visiting practitioners from outside the university centre, might further stimulate interest in the general practice of medicine.

If students are to look with favor on family practice, every step possible must be taken to see that the stature of the family practitioner is maintained on a basis of equality within our own professional family.

The lack of confidence of our graduates must be transformed into self assurance by special training in the complexities of modern practice, and The College of General Practice must make available certification or fellowship, as evidence of the successful completion of such training.

The shortening of the medical course would encourage an earlier decision by the student, whether to seek special training for family practice, or confine himself to some special field of medicine.

The family practitioner would then enjoy the status, the confidence, and the respect, of any other member of the medical family - and this without any **major** increase, but rather a rearrangement, in the present years of study.

If we are to attain this realistic and necessary goal, it must be recognized that:

1. A specialist, because of some special skill in a narrow field, is only more knowledgeable than a general practitioner within the confines of his specialty, and any impressions created to the contrary must be erased.

2. General practitioner and specialist alike must practice the discipline of continuing self-education, for gone is the day when a good bedside manner can replace the results of efficient and good medical care.

3. There must be removed from the tariff schedules and insurance forms any suggestion of differential in fees: and the principle of "one fee for one service" and "one standard of medical care" be the rule, whether it be a house call, office call, hospital call, or any surgical procedure which the hospital staff feels the general practitioner is capable of doing.

4. Specialist registers - by name, by nature, and by purpose - imply the existence of a group of physicians who are set apart from family practitioners. This has an adverse phychological effect on the position and morale of the general practitioner. Might not a better register be one which contains the names of all physicians with their fields of interest so designated?

5. Hospitals must open their doors to all groups of practising physicians, allowing the hospital to decide the extent of privileges granted to each. This should include the provision of specific ward beds, in the teaching hospitals of our medical schools for general practitioners, where both patients and students would profit by the association and attendance on rounds by the doctor who knows, not only the patient, but also the family background.

6. As I said earlier, medical schools, for teaching purposes, must increase, rather than decrease the use of actively practising physicians, both general practitioners and specialists, who are so inclined and willing, and who will prepare themselves for the responsibility. Such physicians must also play a major role on university admission committees in the selection of students for the study of medicine.

It might be suggested that maybe I am a little severe in criticizing the medical schools, and in particular Dalhousie. Ladies and Gentlemen, the late President Kennedy once said, "To state facts frankly is not to despair the future **nor to indict the past**." I like to believe that as Hippocrates suggested, the training of doctors is just one of the many responsibilities which come under the umbrella of the Profession of Medicine, and since medical schools were initiated and nourished by practising physicians, medical education is obviously the concern of the medical profession as a whole. If these remarks appear to be critical, it is in an effort to offer suggestions to this Society as to how a serious situation may be met or to stimulate interest and is done in the exercise of our ancient prerogative as a profession affecting medical schools - a prerogative sadly fallen into disuse of late.

Furthermore, I am not laying all the blame at the door of the universities. Perhaps they are in measure culpable, but we as a profession must share the blame; for though our forefathers in medicine made our medical schools, we their successors have done little or nothing to follow in their footsteps and point out to our schools what the profession as a whole requires. It is generally held that medicine is the most favoured profession of all - favoured in its opportunities for service, in public respect, and in personal satisfaction. But let's recall again the words of President Kennedy "of those to whom much is given, much is required."

We are however, not without one entry on the credit side. A dozen years or so ago, this Society asked for a meeting with representatives of the Medical School. The meeting was held, and a good discussion took place. Complaints from the practising profession regarding the quality of graduates were forcefully and clearly presented, particularly by one of our Cape Breton members, and everyone felt that it was a healthy start. But that appears to have been our last gasp.

I suggest, therefore, that the time is over ripe when this Society should accept a large share of the responsibility for our present predicament and do something about it. I suggest that we have a duty to inform the University of what is needed, and that it is the duty of the University to provide it.

To that end I ask this Society to give broad terms of reference and specific directions to its Education Committee, so that it may present our needs and aims to the educational branch of our profession, namely, the University; and I respectfully suggest that it is now time for the universities and the medical profession to rejoin forces on an equal basis, and in an atmosphere of mutual understanding and respect, and to take a new and forward look at both our undergraduate and continuing educational programs.

I throw out a challenge tonight to Dalhousie Medical School to throw off its conservative and slow evolutionary ways and to adopt a "crashlike" progressive and accelerated program, and lead the way in Canadian medical education and in the provision of doctors for this province. What Pericles said of the Athenians could then be **true** of Dalhousie, "We do not imitate but are a model to others." Let the University make clear that it recognizes the value of non-conformity and courage, and that it welcomes healthy controversy as the hallmark of healthy change.

I call upon the Government of Nova Scotia, and indeed the governments of the other Atlantic Provinces, and this is the challenge to them, to give such priority to the recommendations of the Hall Commission, especially as to financial aid, as will produce such a sufficiency of doctors, that if and when medicare is enacted in these provinces, medicare will be synonymous with quality care.

My final challenge is to the members of this Medical Society to meet their grave responsibility, and by their effort and example, to take such active steps in their communities, in their schools, and in any other place, as will effect the recruitment and the direction of good students towards the profession of medicine; and I ask the Executive to take specific action to impress this serious need upon the membership, so that our Medical School will not be found wanting in the quantity and quality of its applicants. This we must pledge to ourselves.

The decisions and the course of universities and the profession during the next year, may well decide the quality of medical care for the next hundred years. In our hands may rest the final success or failure, of this "quality of care." And so my friends, for the next while ask not what medicine can do for you, but what you can do for the profession of medicine.

Ladies and gentlemen, one of the advantages of being involved in medical affairs, especially in being your President, is the unique and wonderful opportunity of getting to know so well so many of the dedicated people whom I am proud to call my confrères. One of them is the distinguished Dr. T. W. Gorman, our new President, in whose hands I leave you tonight. The coming year will bring the usual measure of problems, but with him and his able Executive, we shall meet the year in full trust and confidence. Thank you very much for the privilege of serving you and good night. ■

PARATAXIS IN MEDICINE

(continued from page 314)

Conclusions

The avoidance of uncomfortable questions is acceptable behavior for an individual but may be a problem when it is practiced by a group. The word 'parataxis' applies in the group setting. Our profession is not immune. Searching for buried questions and displaying them in public may only serve to stir up trouble. If we persist and are lucky, we might also find some of the answers. ■

HEALTH SERVICES IN CANADA

(continued from page 305)

endeavours to assist in the orderly development of improvement in our health services.

For this, I am most gratified.

Another related and very key problem is that of insuring adequate medical care for *all* Canadians, no matter where they may live.

Quite understandably, many of our Doctors are not keen to establish their practices in some of the more remote or less prosperous areas of our country.

We must take steps to make these areas more attractive, because the people who live there have an equal right to adequate medical care.

This will mean the provision of new financial, social, educational, recreational and cultural incentives.

This is something to which my Department will give careful consideration.

Turning now to the role of the health professions, their fundamental responsibility is the actual provision of services.

In the health charter for Canadians which was set out by the Commissioners, the important principle of free and self-governing professions is emphasized.

This implies the right of members of the health professions to practice within the law, to have free choice of location and type of practice, and to have autonomous professional organizations.

As I mentioned a moment ago, the government subscribes fully to this principle.

Rights, however, must always carry with them responsibilities.

The Report recognizes that the major force for improving and extending health services is the health professions themselves.

We believe, and I am sure you share this view, that the greatest advances are to be made by the organized efforts that the health professions take through education and self regulation.

In the words of the Commission, it is only when such objectives are inadequately met, that public agencies act on behalf of the public.

The recognition of the fundamental role of the professions in relation to the quality and utilization of services cannot be over-emphasized.

I know that the medical profession has a very high sense of responsibility, and I am sure that it will be prepared to play its full part.

In conclusion, may I say that the Government intends to spare no effort in doing everything within its power and jurisdiction to provide all Canadians with the highest possible standards of health care.

In this endeavour, it is reassuring to know that we can continue to count on the splendid cooperation at all levels of government, from the health profession, and indeed from all Canadians. ■

As I Saw It - Keltic, 1964*

The 111th meeting has come and gone, amid lovely early fall weather at Keltic Lodge. The motto that Keltic shares with our Province - Ciad Mile Failte - was again proved true. I did not **quite** count up to a hundred thousand myself, but then I had to leave early. The registration for the meeting was the biggest in our history at 130 and those actually in the sessions were up compared with other years.

The Lodge (and who does not already know this?) is set on the spine of a point of land jutting out into Ingonish Bay, so that from the dining room the view on both sides is of the water. And on Monday evening, when Dora trailed her skirts along the seaboard of Nova Scotia, the seas marched into the bay like a never-ending army only to crash as great combers on the fine silvery beach. The view alone, spectacular as it is, was not the sole attraction for the many participants. The comfort and standard of service provided by Mr. Fred Irwin are justly renowned. The cuisine is excellent, and the waitresses are a pleasure to watch (yes, they are pretty too.) The golf course, with its billiard-smooth greens and its fairways that could stand for greens on many a course, is a giant killer. One guest shot 110, when at home he averages 85. But he says that he is coming back next year for another bite. He claims that he knows the way round now and could shoot for double figures. The course was, needless to say, crowded. Rumour came through that the salmon were running at the Margaree. And **still** the business sessions were pretty well attended!

For many of us the meeting started on the Saturday with the sixth regular meeting of the Executive Committee. Here the attendance was over 80% and the delegates stayed at work all Saturday and much of Sunday - as they do, incidently, five other times through the year. It is a good club, that. Why not join it some time?

The 'sixth regular' was enlivened firstly by a discussion of the licensing of doctors and whether there should be a College of Physicians and Surgeons who would be the licensing body and of which membership would be mandatory to preserve one's licence. This is done in other Provinces, notably Quebec. Our scheme is based on the one that works so well in England. This has been batted about from time to time ever since Dr. Wickwire's committee had it in 1956. It came up again at the request of the Provincial Medical Board, but also partly because the Bar Society is interested and partly because there has been some question as to whether the P.M.B. has the power that it needs for policing, and whether it is using its powers effectively. There seems to be no doubt that the powers are there, and equally, where we nominate six of the thirteen members of the Board, there is every reason why the Society's voice should be clearly heard. Dr. Woodbury agreed to head a committee to look at this again, and our representatives on the Board took the feeling of the meeting under advisement.

The Joint Study committee reported on happenings since the special meeting of the Executive approved certain modifications to the fees that the

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*An on the spot but off the record account of the 111th Annual Meeting. Opinions expressed are the Author's own.

Society will accept from M.M.C. It will be remembered that as a result of this meeting M.M.C. were able to start paying the 1963 schedule (as modified) last July. There has been some dissatisfaction by two branch Societies, but after meeting with representatives of the Executive to explain the good reasons for what was done they were much mollified. Three specialties had specific problems, viz: Paediatricians, Internists and Ophthalmologists. Recommendations have been sent to M.M.C. to deal with these and there is every hope of them being accepted. This whole discussion brought out the value of the Sections within the Society, and the importance of their speaking to the parent body **before** they start complaining to anybody else.

The Medical Economics Committee is very busy just now, both in the Society and at C.M.A. level. They brought in a long report on their discussions of different possible Medicare plans. This report is still under discussion, and a C.M.A. committee meeting immediately followed our own annual meeting, so that there is nothing concrete to report now. However THE BULLETIN hopes to give you all the relevant details in an early issue. One thing is however certain. Your Executive believes that if Government insists on total support of all groups we should withdraw our support for subsidy by service of the indigent groups.

The afternoon was enlivened by a request from the P.E.I. Division to sponsor the 1965 meeting of the C.M.A. in Halifax, June 14th to 18th. This was recommended to the Society, as was the Application of the Eastern Shore doctors to be constituted as the eleventh Branch Society of the N. S. Medical This is entirely in the spirit of growth of medicine in our Province today.

The Society has written to Mr. Frank Rowe, Q.C. to inform him that we are interested parties in the field of Medical Insurance, and offering our help in the researches of his Medical Services Advisory Committee.

The Annual Meeting of the Executive occupied Sunday. This meeting looks at all the Committee reports to be given at the Society's Meeting and makes any Executive recommendation needed.

To pick but a few from the 28 standing committee reports, The By-Laws Committee has completed its work in conjunction with the Society's lawyer, and the Executive, and with a few modifications from the Executive presented the new By-Laws for the Annual Meeting. This has been a great labour, and whether or not you agree with their central recommendation for a Council they are justly proud of the result. The Cancer Committee reported steady progress, with a note that the results of the Provincial 'Pap smear' programme are most gratifying in finding early cervical cancer. The many cases of *in-situ* carcinoma found are protected against later invasive disease and possible death therefrom. It seems well to reiterate the value of any practitioner who does not yet do them routinely looking at the possibility of starting. There is no charge by the Province for the examination and advice on how to go about it is freely available from any Provincial Laboratory.

The report of the Committee on Discipline is quoted *in toto*: "I am glad to report that during the year 1963-64 there has been no problem brought to the attention of the Discipline Committee".

The Editorial Board foreshadowed a larger and hopefully improved Bulletin - dictated in part by economics. The change is slated for January 1965.

The Fees Committee had a busy time a year ago, and most of us are glad to bury the differences that occurred then. This year they have merely had to cross a few T's and dot some I's.

The retiring Finance Committee had to report that the Society has been losing money for some years past, to the extent that to pay all bills we must close out our savings account which stood at $8500 in 1960. In the Treasurer's view there was no escape from an increase in dues next year if the Society is to continue to do the work that it is now doing for doctors in Nova Scotia. The Executive, while agreeing to the economic facts did not feel that they could impose this on the members without a year's warning, and suggested borrowing for the time being. Of this more later.

It is to be noted that a Select Committee has been authorized to examine the Secretariat, including its composition and responsibilities.

The Health Insurance Committee has been well rewarded in the results of their meetings with the N.S.H.I.C. and a satisfactory formula for Pathologists was achieved.

Membership. Of some 840 Physicians on the N. S. Register in 1964 (some interns, some in postgraduate training and some retired or otherwise not in active practice) 554 were in good standing on August 15th and with 107 in arrears we have a potential membership of at least 660 this year if all pay their dues. With membership in the Society voluntary, this, while a satisfactory percentage, leaves room for improvement. The Treasurer remarked that an increased enrollment would go far towards balancing the books.

Traffic Accidents. The Committee has studied the question of breathalyser tests, and recommends that the Attorney General's department be encouraged to make these admissible in our courts. They have also made a recommendation that seat belts be fitted to all cars, and studied other means of preventing accidents and of minimising their impact. Physical and mental standards of fitness for drivers should be established in Nova Scotia.

Dr. Titus' Committee on W.C.B. liaison has achieved their object with agreement that W.C.B. will base payments on the 1963 schedule with 10% proration. This appears to be an excellent result.

Special committees of interest include the Medical-Legal Liaison. The worst of the beefs, both by doctors about lawyers and the other way about, have at least been transmitted to the other side, removing much heat in the process. Dr. Griffiths and Mr. Kanigsberg are well on the way towards the formation of a Medico-Legal Society of Nova Scotia, separate from but sponsored by both Professional Societies. The first branch is expected to meet in Halifax this fall.

The Specialist Register is now virtually in effect. At least the P.M.B. have agreed to implement it. The Committee asked leave to disband.

Sunday night and Monday morning brought the membership out in force in time for the first business session of the Annual Meeting of the Society. Some thought that by 4 am there was quite enough force. . . . . .

This meeting was the last that Dr. Lea Steeves presided in his capacity as Chairman of the Executive. He has his rivals, but few can think of a better, and we all owe him a great debt of thanks.

The Treasurer brought his Finance Committee report in early on Monday morning, and at once there was an impassioned plea from the floor to raise Dues, not by the $10 that the Treasurer advised but by $15, as being enough to hold the line for three or four years to come and not just for next year. An amendment to reduce this to $10 was received by most of those present with relief, even if we do have to up them again in a couple of years. But perhaps we won't - after all, pigs might fly.

The Editor, in foreshadowing the changes in the Bulletin to come, acknowledged the great debt the Society owes to the O.M.A. and to Dr. Glenn Sawyer in offering us the advice and assistance of the Advertising Manager of their REVIEW, Mr. Cliff Goodman. At a later point in the meeting Mr. Goodman was introduced to the members and presented with a token of our thanks. The Editor tells me that during the week he learned much about Journal publishing.

The Committee on the Specialist Register was complimented on the result of their labours and allowed to disband.

When the time came for the report on By-Laws it all went through with remarkable little objection even to the Council. Let us now hope that this change will have the effect desired, which is to encourage attendance at the Annual Meeting, and thus to spread the effective franchise to some who we see too rarely at meetings.

The biggest interest on Tuesday Morning was in the sphere of economics, with encouraging reports from the committees concerned, as mentioned above.

The Society were glad to approve a new Branch Society to their ranks, from the Eastern Shore. Representative Dr. J. A. McPhail. Welcome, Eastern Shore Medical Society. Now we are 11.

The Panel discussion on the Hall Commission Report which occupied a good part of Tuesday afternoon served to shew that Nova Scoia is well in the fore on the research side regarding Health Insurance. The Press were represented and most will have seen the reports that they prepared. The impact of the Hall Commission report is only just beginning to be felt, and while many of its recommendations are in line with our own thinking, many are not. There is a lot of hard work to be done here in the next year or two.

The new Officers were elected on Tuesday afternoon. The Nominating Committee in their turn have done well by us. Tony Griffiths is a universally popular choice for President Elect, and if we must lose Lea Steeves and Jack Boudreau both in the same breath, who better to replace them than Stu Robinson and Don Vair. Dr. C. E. Kinley, Jr., a promising young man, has been elected Vice Chairman of the Executive Committee.

Wednesday was the Clinical day. Dr. Hamish McIntosh gave us an excellent and most practical guide to the investigation and management of renal calculi. The Editor hopes to be able to publish the text of his address for those who were not able to be there.

After that a series of small group clinics, rather after the lines of those given at the Dalhousie Refresher Courses in the fall, made a change from the usual pattern. They created much interest and deserve to be repeated.

Our story would not be complete without mention of our honoured guests. Dr. Frank Turnbull, President of the C.M.A. came to many of our sessions and made many friends. The Association is fortunate in its Presidents.

We were most happy to see both The Hon. Judy LaMarsh, Minister of Health and Welfare of Canada and the Hon. R. A. Donahoe, Minister of Public Health of Nova Scotia. Both were kind enough (as was Dr. Turnbull) to leave us copies of their Addresses. They will appear promptly in THE BULLETIN.

And so the stage is set for the 112th Annual Meeting at Halifax in 1965, a conjoint meeting with the C.M.A. We have been invited by the Prince Edward Island Division to take over their mantle as Principal Hosts on that occasion. This we are most happy to do. Thank you, P.E.I., we are glad to share this honour with you.

Lucidus. ■

Golf Tournament 1964

We were charged to run three separate events, one for the men who are members of the Society, one for the ladies and a third for the drug and commercial exhibitors. Because of the length of the Keltic Lodge Golf course and the time involved to play 18 holes, we decided this year to run separate 10 hole conpetitions as well for those who could not get around the entire 18 holes. This was restricted to members and ladies only.

Nearly 70 people played sometime during the allotted time of the three tournaments from Monday to Wednesday, in spite of a hurricane rain which spoiled most of Tuesday for playing. With the emphasis given this year to recreation, especially for physicians, the golf was a perfect answer.

With some frantic last minute arrangements, the following were the winners and their prizes were presented at the Annual Banquet on Wednesday evening:

MEN'S 18 HOLE COMPETITION

Winner – Low Gross: Dr. Roy Moreash, Berwick, N. S.
Runner Up – Low Gross: Dr. A. W. Titus, Halifax, N. S.
Winner – Low Net : Dr. D. L. Roy, Halifax, N. S.
Runner Up – Low Net : Dr. A. L. Shears, Halifax, N. S.

MEN'S 10 HOLE COMPETITION

Winner – Low Gross: Dr. G. McK. Saunders, Amherst, N. S.
Winner – Low Net : Dr. H. B. Ross, Halifax, N. S.

LADIES TOURNAMENT

A new trophy was donated this year for the Ladies' championship by Dr. W. A. Curry of Halifax, N. S. It is Dr. Curry's wish that three wins by one person shall mean permanent possession of trophy. This was awarded this year on the basis of 10 hole competition because of the length of the Course and winners were:

Low Gross Dr. Marjorie Smith, Halifax, N. S.
Runner Up – Low Gross: Mrs. Thomas McKeough, Sydney Mines, C.B.
Low Net Mrs. John Williston, New Glasgow, N. S.
Runner Up – Low Net : Mrs. A. E. Murray, Halifax, N. S.

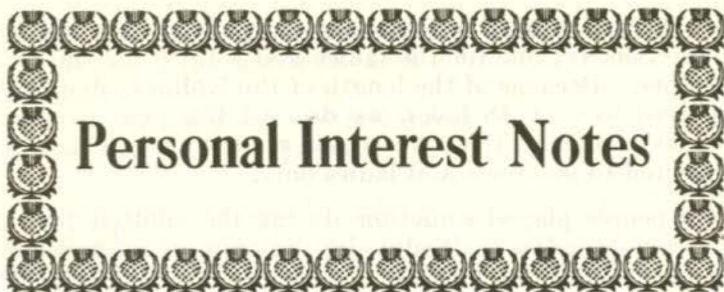
A special prize for 18 holes was given to Mrs. K. M. Grant as being the only woman to play all 18 holes.

DRUG AND COMMERCIAL EXHIBITORS TOURNAMENT

Winner – Low Gross: Bryson Crowell
Runner Up – Low Gross: Piper MacMillan
Runner Up – Low Net : B. Annis
Winner – Low Net : J. D. Otto

A special prize of **golf balls** was donated by the Upjohn Company of Canada through the kindness of Mr. Matheson, Mr. Annis and Mr. Hinton.

A.W.T.
K. MacL.



Those of us who read the Halifax papers realize what a good publicity job is being done in aid of funds for the new Children's Hospital by special articles featuring among other aspects the many and varied avenues of research that are being investigated by Dr. W. A. Cochrane, Dr. Ozere and others within that cramped, old fashioned building.

All doctors throughout the province must realize what a valuable and vital centre it provides for their small patients. Contributions are slow in coming in. There are many calls on all of us but some are more compelling than others. This appeal comes once in a generation yet who can tell when that hospital may be of PERSONAL INTEREST to us or our own loves ones?

LUNENBURG-QUEENS MEDICAL SOCIETY: DR. R. N. HETHERINGTON, now of Lunenburg, has recently joined the staff of the Dawson Memorial Hospital as certified anaesthetist. A graduate of Cambridge and Queen's University, Belfast, he has served as anaesthetist in the Canadian Army since 1947 with service in Korea and across Canada. Lt. Col. Hetherington retired in June 1964 as chief anaesthetist at the Tri-Service Hospital in Halifax. Dr. Hetherington will alternate services with Dr. Darrell Donaldson, Mader's Cove on the staff of the Dawson Memorial and the Fisherman's Memorial Hospital.

AMHERST: DR. E. G. KELLEY, Havelock St. is convalescing from a broken leg and arm suffered when his car left the Trans-Canada Highway at Aulac in a dense fog after hitting a soft shoulder. He was alone at the time of the mishap!

HALIFAX: DR. ROBERT MURPHY, specialist in Otolaryngology, has returned with his family from St. Louis, Missouri, and is now associated with Dr. C. F. Keyes. Dr. Murphy is a graduate of the University of King's College and of the Dalhousie Medical School.

BIRTHS

To Dr. and Mrs. James Smith (née Frances O'Brien), a daughter, on September 17, 1964, at the Grace Maternity Hospital.

Congratilations

Congratulations are in order to Dr. Donald M. Nicholson, a graduate of the Dalhousie Medical School in 1960. During his undergraduate years he was from his freshman year an outstanding ball carrier for the Dalhousie football team. Since graduation he has been taking postgraduate training in Surgery at the Victoria General and Children's Hospital in Halifax. He has now been awarded the R. Samuel McLaughlin Foundation of Toronto Fellowship. Dr. Nicholson left last week for Oxford, England, where he will spend a year in the Traumatic Surgery Unit at the Ratcliffe Infirmary, under Dr. J. C. Scott, F.R.C.S.

Established in 1951, McLaughlin Fellowships are awarded in limited number each year to Canadians who have been selected for appointment on the permanent clinical staff of a Canadian medical school and one of its affiliated hospitals. Dr. Nicholson will return to Halifax following this year at Oxford.

We also congratulate John David Sproul, M.D.C.M., F.A.C.O.G., formerly of Wolfville, now of New York City and New Preston, Conn., on his appointment as assistant medical director of Ayerst Laboratories. A graduate of Dalhousie Medical School, Dr. Sproul is director of the gynaecology clinic, Jewish Memorial Hospital, N.Y.C., and in charge of resident teaching and research.

Contest Winners

Many and varied are the hobbies of doctors.

Over the Labour Day week end, Dr. Harris Miller, Halifax, won the all-gauge trap and skeet honours in the invitation meet at the Dartmouth Gun Club. He has also been elected president of the Maritime Trap and Skeet Association. He shares honours in the sport with Dr. Doug. Coupland of Rockingham who won the 20 gauge skeet championship after a seven-way shoot off. Other doctors taking part were Dr. D. R. MacInnis, Shubenacadie, Dr. Forbes MacLeod, St. John, and Drs. M. Brannen and W. Verge of Dartmouth, Dr. Art Ormiston of Sydney and Dr. H. Leslie Stewart of Halifax.

Belvedere Contest Winner: FIRST PRIZE - Dr. Charles McDonald, Halifax. Ford Galaxie Convertible, PLUS $150 a month for ten years. What will the AMA and CMA say to him! What about the CHILDREN'S HOSPITAL Dr. Charlie?

RESIDENT TRAINING IN OTOLARYNGOLOGY

Applications will be received by Dr. J. S. Hammerling, Professor of Otolaryngology, Faculty of Medicine, Dalhousie University c/o of the Postgraduate Division, Dalhousie Public Health Clinic, Halifax, N. S., for the year commencing July 1st, 1965. This University sponsored programme in the teaching Hospitals of Halifax is approved by the Royal College of Physicians and Surgeons of Canada.

Clinical Conferences

Since the August Bulletin was published the 'open' rounds and conferences in the Department of Medicine have been revised. We regret any inconvenience that may have arisen, and publish the following up-to-date list:

COMBINED CONFERENCES

VICTORIA GENERAL HOSPITAL 1964 - 65

12:30; - 2:00 p.m. — Out Patient Conference Room

Monday –		Cardiopulmonary
Wednesday –	1 and 3	Haematology
	2 and 4	Gastroenterology
Thursday –	1 and 3	Endocrinology
	2 and 4	Neurology

Fourth Floor Clinic Room

8:00 - 10:00 am. — Fourth Floor Clinic Room

Tuesday — Medical Grand Rounds

9:00 - 10:00 a.m. — Conference Room - First Floor Pavilion

Wednesday - Neurology - Neurosurgery

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