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The NOVA SCOTIA MEDICAL BULLETIN

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Editorial

Family Centered Care

The Canadian Conference on the Family, called together last June in Ottawa, represents a personal achievement of Governor-General Vanier and his charming and energetic wife, that will have a continuing impact on social and health services in Canada. Three hundred individuals were selected from all professions and walks of life across the nation to discuss the relationship of the family to Canada's social problems, to our public and private community programs and to the aspirations of the Canadian people to a richer and better life. Three sociologists and a psychiatrist made major contributions. The presentation by Dean Kasper Naegele, who has taught Medical Sociology at U.B.C. for some years, received a standing ovation. Frederick Elkin's summary of available data on "The Family in Canada" was prepared in advance [1] and is an excellent source book. Many smaller special studies were also prepared before the meetings. Of particular interest was the paper by Dr. N. B. Epstein, Associate Professor of Psychiatry at McGill, on "The Inner Life of the Family". Dr. Epstein has developed an interesting method of group interviewing of the family together, by the whole mental health team at the same time, that is being used in one of the Nova Scotia mental health units.

The focus of the many workshops and study groups was not the patient, or the delinquent, or the relief recipient, or the gifted child. Neither was it the health insurance program, the juvenile court system, the welfare services, or the schools. We were constantly reminded of the central role of the family in our society in providing the framework through which all these social and medical services are made effective. Our social problems were described as the result of forces that break down the ability of the family to cope with the demands of modern living. The goal of our medical and social services was seen as the strengthening of family life, where feasible, so that the family could fulfill its essential functions of emotional and economic support, technical and spiritual education and health care for family members. The peculiarly vulnerable position of the single person, the widowed, the orphan and members of broken or disorganized families was recognized as requiring special services. Hospitals and out-patient clinics are all too familiar with some of these "multi-problem families". However, attention was given to the impact of the pressures of modern life on the "normal" families that make up most of our society.

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1. Elkin, F., "The Family in Canada", The Canadian Conference on the Family, 55 Parkdale Avenue, Ottawa 3, (pp. 192), April 1964.

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There seemed an obvious need to fill gaps in existing services, and even more to co-ordinate the many health, welfare and medical care services that are essential if the average family is to deal effectively with such problems as sickness, death, unemployment, or deviation from our society's standards for acceptable behaviour, by family members. We were reminded that the organization of our medical and social services, and the training of our health and welfare professions, often tends to fragment the family, and to offer service to individuals as if they existed in a social vacuum, either ignoring the inter-relation of family members or even tending to weaken or destroy it. This seems to us to be even more true of health services than of welfare services, and to apply particularly to medical and hospital care - points the conference charitably did not underline as much as it might have.

Most social events cast their shadow before them, and this conference was a reflection of deep concern in many nations today over the changes we must make if the family is to function effectively in 1964. Much has been written recently on the fragmentation caused by the organization of our medical services and by the present training of our physicians and other health professionals. Dr. George Silver of Montefiore Hospital in New York, in his recent book "Family Medical Care", discusses the patient's perception of the "family doctor", and one experiment in meeting the family's need for such a generalized service in cities where the vast majority of physicians are specialists. The inevitable division of labour we call specialization will continue as medical knowledge becomes too extensive for one man to keep up with and as urbanization and the organization of hospitals and other medical care services makes such specialized medical service more efficient and more satisfying for the physician. As a partial solution to the resulting breakdown of family centered care, both Epstein and Silver's work point to greater use of groups of medical and paramedical personnel in teams dealing with the whole family.

Studies of "the hospital and the community" sponsored by the Nuffield Foundation in Scotland, describe patients observed for several years after hospital discharge, and note the failure to use existing community resources adequately.

A general observation was that the prognosis for social function of the patient after discharge, made by the physician in hospital, and often even the medical prognoses, underestimated the difficulties the patient in fact later encountered. All too frequently the employable were not employed, the family was unable to cope with the patient's needs, preventable disabling sequelae of chronic illness were not prevented, necessary continuing care was not received, and the patient ultimately returned to hospital worse than when he was discharged. These findings were not greatly changed in one study where an attempt was made to use existing community services more fully, but where we would assume each medical man, hospital or community agency worker functioned in his usual patient - oriented or agency - oriented groove. Third year students at Dalhousie in the social medicine teaching unit of the Department of Preventive Medicine, will find these observations familiar.

The better experience of Silver's family-oriented team operation still leaves many unanswered questions, as he is the first to point out. Comprehensive care experiments at Colorado and Cornell are promising, but still being evaluated. The decision of the University of British Columbia Medical School, under the leadership of Dr. McCreary, to emphasize joint education of medical and paramedical personnel as a step towards a pattern of health service better suited to family needs, will be watched with interest. ■

G.H.H.

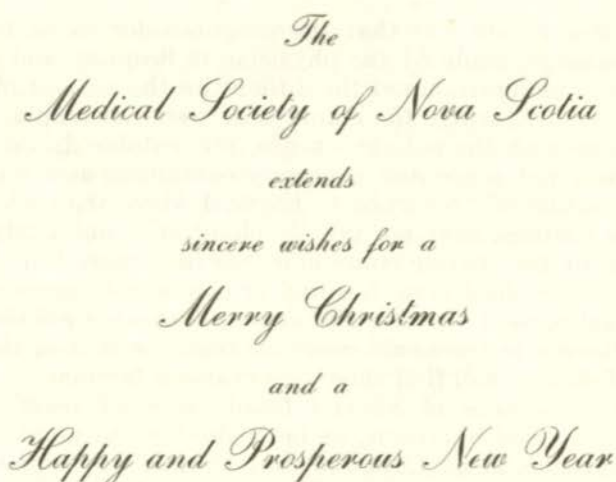
The
TRANSACTIONS
of the 111th Annual Meeting
Keltic Lodge Sept. 12th - 17th, 1964

Your editor had hoped to publish the Transactions of this Meeting in the present issue of The Bulletin.

It has unfortunately not been possible to prepare this material in time, and it will therefore appear as a special supplement to the January 1965 issue.

The indulgence of members will be appreciated.

The Editor.



Medicare and the Prepaid Plans[†**]

Irwin W. Bean, M.D., M.C.G.P.*

In preparing these few remarks on the role of the prepaid plans under a government-sponsored system of medical insurance, and trying to relate them to your particular situation in Ontario, my problem was not what to say, but what *not* to say.

To review the Saskatchewan plan and the Alberta plan in detail and then relate them to the Ontario problem, just would not work. The populations are different, the economy is different, there are certain differences in our prepaid plans, and certainly differences in the philosophies of our respective governments. It is obvious that if we are to compare our approaches to this problem, we must find common ground - a common denominator.

In the search for this common ground, I considered the fundamental principles of medical economics as they have applied throughout our country for many years. This is the one common denominator we find in a country as vast as Canada, where health care is a provincial matter. It is often amazing to me how much we have in common in our approach to our economic problems.

This topic is a purely economic one. I am certain that the doctors in Ontario do not dispense their patient care by the dollar value anymore than we do in Saskatchewan. We care for our patients in accordance with their medical needs, irrespective of their ability to pay. Such is the time-honoured tradition of our profession. We also recognize the fact that, as with any service or commodity, it is the consumer (or patient) who establishes the demand for our service. What we are really attempting to define in our present discussion is how we, as physicians, can help the patient pay for our services, and who should do this. We are entering the field of pure economics. Let me assure you that I am no expert in this field and do not pretend to have any more than a very elementary knowledge of it. Just like you, I practice medicine and limit my economics to basic principles.

I want to discuss some of those basic principles. If they seem too simple and fundamental, I would ask your indulgence. With all due deference to some of our economic experts these days, these very fundamentals would appear to be the principles they would like to forget.

There are three integral parts to our problem: (a) Prepaid plans; (2) Government sponsorship; and (3) Insurance. I would like to speak briefly on each of these three in order to obtain some meaningful definitions.

Insurance:

Traditionally, this is a contract between the insuring agency and the insured, which involves a payment by the insurer to the insured in accordance with the terms of a contract. If we follow pure insurance principles in medical economics, the physician sends his account to the patient, who is responsible

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†Delivered to Scarborough Clinical Society, Sept. 30, 1963.

*Director, Saskatchewan Division, C.M.A., and a medical representative on the Medical Care Insurance Commission.

**Reprinted from the Ontario Medical Review February 1964.

for the payment of the account. The patient, in turn, recovers all or part of the moneys and deals only with the insuring agency. For convenience, he may waive the payment in favour of the physician but he remains responsible for any differences which may arise. This has been the traditional pattern of sickness and accident insurance sold by many companies throughout the years. It has advantages and disadvantages to all parties, as we are aware - administrative forms, non-payment of accounts, physicians' accounts in excess of the amount paid by the insuring agency, patients not understanding their insurance contract, etc. The chief advantages are that the patient knows the extent of his coverage (if he takes the trouble to read his contract), the company knows the extent of its liability, and the physician retains complete economic freedom, in that he deals only with his patient. His fee is based on the time-honoured tradition of the profession, namely, the time, skill and effort required, and the patient's ability to pay.

Prepaid Plans:

In Saskatchewan these were inaugurated in the late 1930s and early 1940s Two groups were involved - the providers of the service, or the doctors, on the one hand, and the consumers of the service, or the patients, on the other. Being co-operatively minded, the patients formed a Consumer's Co-op, which was an attempt at mass purchasing of medical services. They approached the profession to accept payment from their organization as payment in full. This, the profession refused to do. As a result of this, the life span of their organization was relatively short. The physician-sponsored plan followed the same principles of development as your P.S.I. Our basis for giving any agency a contract to accept payment from them as payment in full was clearly stated: (1) The scheme must be voluntary; (2) There must be medical control of the administrative board; (3) That board must have fiscal and administrative autonomy for the plan must operate at cost (non-profit).

When the Consumer's Co-op dissolved, it was absorbed by the medically sponsored plan. We allowed the subscribers to elect one-half of the board and the profession the other half. Thus, we attained the union of a producer's co-op and a consumer's co-op, which worked well until our present Act came into being. This was Group Medical Services. Medical Services Incorporated was organized in Saskatoon and was completely medically controlled - all board members, both lay and medical, were elected by the profession.

Similar plans developed and flourished in all provinces. In my opinion, their importance has been that the profession has indicated its willingness to enter into a contract with the consumers of our services to accept payment from an agency as payment in full where certain criteria are met.

Government:

I have previously expressed the opinion that any government interest in medical affairs is not, and never was, medical. It was and is, political - designed to increase the power of the political apparatus for the control of people. Most Canadians will pay taxes at a high level fairly willingly with the knowledge that a fairly large piece of the tax dollar is going to the less fortunate people in their country through welfare payments, where need is established. However, as Mr. Kilgour, President of the Great-West Life Insurance Company said recently, "Santa Claus is still the favorite Canadian idol". Everyone is looking for that something for nothing.

With an over-abundance of the dreamer types who softly sell the vision that they can legislate our problems away, it is not difficult to see how the unsuspecting voter gets "sucked in" by the concept that governments can actually do things cheaper and more efficiently than he can. So governments, which if they are to be re-elected must do what is politically expedient, see this field as a particularly fertile one. It has universal appeal, in that illness will ultimately affect all people.

Any government whose philosophy is based on a controlled economy (which is really control of people) will not be satisfied with sponsorship of medical insurance, but will aim at a completely state-controlled service. On the other hand, a government that is as anti-socialist as the Alberta government, is satisfied with mere sponsorship.

Whether the public can wisely turn over its monies for the payment of medical care to the wisdom and political pressures of an elected government, is a question which must be thoughtfully appraised.

Before I discuss the plans in Saskatchewan and Alberta. I would like to add two more observations in order that we may maintain the proper perspective. The first is that physicians, as members of a responsible profession, are self-disciplining. The second is that physicians, as citizens, have the right to set their fees for their services and the legal right to sue for it.

Saskatchewan:

Although our plan is called a Medical Care Insurance Act, it prostitutes the very meaning of the word "insurance". It is a compulsory tax on all citizens, designed to make the payment for health care a state-given right and aimed at the complete control of the providers of the service. It follows much the same pattern as the Hospital Insurance Plan in our province, which has expropriated our hospitals in all but name.

The role of the prepaid plans in such a scheme is limited indeed. We manage to maintain a voluntary membership in the plan, its non-profit elements and its medically controlled board. However, the board has no fiscal or administrative autonomy and its medical members must accept government assessment and payments of accounts as payment in full. Their sole purpose is that of an agent for both subscribers and physicians for dealing with government. They become a middleman or broker without any fiscal liability.

The philosophy of our government is aimed at centralized control of administration and consumer control of cost (the consumer in this instance being represented by government). This is the first time in economic history, to my knowledge, that the consumer of a service, who controls the demand, also controls the cost. By legislative act and regulations controlling the prepaid plans, government has effectively limited our ability to alter our schedule of fees. Any change in the fee schedule, if it is to affect the rates of payment by the Commission, requires an Order in Council, and must be negotiated with the Commission. To date the rate of payment by the Commission has been 85% of the schedule of fees, as amended to April of 1962. We have refused to negotiate any changes with government, believing it to be our prerogative to set our own fees. However, if it is so wished, the Commission could rewrite the entire fee schedule and pay only as it sees fit.

Despite the fact that the College is responsible for the disciplining of physicians under the Medical Professions Act, the secrecy provisions of the

Medical Care Commission are so restrictive that it is illegal for the Commission to give the required information to the College to take disciplinary measures. Yet, any patient's account or accounts, or physician's income can be discussed upon the floor of the Legislative Assembly, if requested by a majority of the members present. As has been said of the British Health Scheme, it is a pretty awful mess.

However, in all fairness, I doubt if there is a plan on the North American continent that is paying its accounts any faster. The average time of payment from the time of receiving the account is two weeks.

The prepaid plans, acting as an agent for the subscriber, have acted as a buffer between the subscriber and government, and have made the plan generally acceptable.

Alberta:

The Alberta plan, being a voluntary one, has attempted to follow the insurance principles. It is designed to be a dollar subsidy based upon need (up to $500 taxable income per year).

Their physician-sponsored prepaid plan remains unchanged and, along with some 47 other insurance companies, makes the plan operative.

The government has utilized the existing agencies. They sell the contracts to the subscribers, apply to the government for subsidies, administer their own plans and referee and pay their own accounts. They must maintain certain statistical information for the government, but this is kept at a minimal level. There is a central medical referee committee established to adjudicate problem accounts. The agencies sell a first-dollar coverage contract and also limited liability contracts with co-insurance as the subscriber desires. The contracts provide for a limited waiver of premium in the event of prolonged disability. The agencies have the power to cancel a subscriber's contract for misuse. The rates are set through a co-ordinating directorate consisting of one representative of government, one from the College of Physicians and Surgeons, one from the medically sponsored plan and one representing the 47 other carriers. The payment to physicians is on the basis of the College schedule of fees, as from time to time amended by the College.

The governmental philosophy here is based upon the belief that medical and health services must remain the responsibility of the individual. Society collectively is responsible to assist those who cannot provide it themselves. The indigents are completely covered, the semi-indigents can be assisted if they so desire, and those who do not require assistance are self responsible. There will undoubtedly be some people who are eligible for subsidies who will not apply for medical insurance. In these cases, as in the past, the medical profession will care for their medical needs and write off the accounts.

This plan is based upon the recommendations of the Saskatchewan College of Physicians and Surgeons to our government some 18 months ago. It has the advantage of being voluntary, yet universally available. It provides for decentralization, the only central body being the co-ordinating directorate. The control of the cost is in the hands of the providers of the service - a responsible profession.

Ontario:

I am certain that all present are far more knowledgeable concerning the detail of the Ontario plan than I. However, in its present form, it would appear to meet the requirements of the profession. (1) It is voluntary, but uni-

versally available; (2) By utilizing existing agencies, it follows sound insurance principles; recognizing the varying insurance needs of the individual, it offers three standard contracts; (3) It makes provision for professional responsibility in the establishment and amendment of the fee schedule; (4) The governmental philosophy as expressed is aimed at co-ordination rather than complete domination.

Now that you are politically stable again and the Bill can get into its third reading, the main thing to watch is the regulations under the Act.

Benefits:

While the Saskatchewan plan has some exclusions, in that it makes the payment for health care a state-supported right, these are minimal. It pays for a routine medical examination annually. However, in order for the patients to obtain this benefit, every practicing physician in the province would have to do an average of ten routine physical examinations per working day and in so doing would have little or no time available to care for the sick. The Alberta plan has similar exclusions and provides for annual medical exams after two years in a plan. I was pleased to see that Ontario excluded annual examination. While these may be very desirable from the point of view of preventive medicine, it is generally recognized that we do not have sufficient doctors in Canada to achieve this idealistic state.

But why are we so concerned in this economic mess? We are doctors, who are primarily concerned with treating our patients, and even our government has assured us that they would never interfere with our professional judgment. All they want to do is pay the bill on behalf of the patient. Why, then, the concern?

I believe that we tend to overlook an obvious facet in our practice, because it is so obvious. This is the doctor-patient relationship. Everyone talks about it, but rarely do we take the time or trouble to analyze it. Simply stated, I believe it is a friendly contract; friendly in that we usually like our patients and they usually like us or they would not be our patients; a contract; in that both parties have legal responsibilities, and while never signed or witnessed, it is entered into in good faith by the parties involved.

We, as physicians, must treat the patient to the best of our knowledge and ability and maintain silence. The patient contracts to pay for the service rendered to him at a rate set by the provider of the service. This is the type of contract that he enters into daily when he purchases any other goods or service, and is his responsibility. If he wishes to purchase insurance coverage for the cost of the services, he should be free to do so, but the economic controls imposed by a government such as ours seek to strip the patient of his responsibility in the doctor-patient relationship and strike at the very roots of our democratic society. It conditions the people to being controlled in one vital area and aims at controlling them in all areas. Our freedom is not a commodity which we may unilaterally barter away. It represents the freedom of our patients as well.

In concluding, I would like to say that in principle, I like the Alberta plan. I am sure that it will have some shortcomings and administrative headaches. However, the governmental philosophy has inspired the trust and co-operation of the medical profession and these teething problems should not prove insurmountable. I prefer the utilization of multiple carriers, including the insurance industry, to that of having one or two large physician-sponsored

plans having a monopoly on the field. The danger lies in a change of governmental philosophy which depends upon the whim of the electorate.

In Saskatchewan I see no meeting of the minds between the profession and our present government. We think as individualists; they think as collectivists. We believe that the Medical Care Plan should follow sound insurance principles; they look upon it as a type of "social insurance" with complete government control. It will only be by returning to these insurance principles (which is allowed under our Act) that we will regain our professional freedom. This will mean only dealing with our patients and have them in turn deal with their compulsory insuring agency. Such a move will require the ignoring of the Medical Care Commission and doing away with our present prepaid plans. ■

FROM THE BULLETIN OF 40 YEARS AGO

From The Medical Society of Nova Scotia Bulletin, November 1924

Many years ago it was noted that Graves' Disease can be divided roughly into two groups; those with exophthalmos and those without exophthalmos. One of the greatest advances in our knowledge of thyroid disturbances is the sharp differentiation between these two groups. One recognizes first exophthalmic goitre which is characterized by exophthalmos, and by a pathological picture of marked hyperplasia of the whole gland. Secondly, there is thyroid enlargement with increase of metabolic rate and is characterized by an actively growing adenoma, or possibly more than one. In this group, there is no exophthalmos. The differentiation is very important since the latter cases (those of toxic adenomata) require surgical treatment as soon as possible provided that the patient is a good risk. The results of such operations are uniformly good. On the other hand, surgical treatment of exophthalmic goitre is not yet accepted as the only cure. There are several other points of differentiation between these two conditions—for example, in exophthalmic goitre, in addition to prominence of the eyes, there is a diffuse enlargement of the thyroid. It occurs in a woman under forty generally, the condition frequently comes on suddenly and the patient may be able to set an exact date for its onset. The enlargement of the gland is of less than two years' standing. While the systolic blood pressure may be raised, the diastolic pressure as a rule does not rise proportionately. In toxic adenoma there may be found a definite nodule in the thyroid gland. There has been a goitre extending over a period of fourteen or fifteen years. The onset of the hyperthyroid symptoms is insidious. The patient is generally approaching the menopause or is at least forty years of age. There is generally a definite hypertension the diastolic as well as the systolic pressure being raised. These distinctions are somewhat arbitrarily made, and of course, are subject to many exceptions.

Extract from the address on goitre by Dr. G. S. Young to the Pictou County Medical Society, Oct. 1924. ■

Dalhousie Notes - 1964

C. B. Stewart, M.D., Dean

Ten years ago, shortly after becoming Dean of Medicine, I rather ambitiously undertook a series of "Dalhousie Notes" for the Nova Scotia Medical Bulletin. The pressure of other duties caused a progressive lengthening of intervals between these notes and eventually they stopped completely. During the past few years I have also started several reports designed to describe the activities and plans of Dalhousie Medical School but they too went unfinished.

Occasional news items have been reported recently - that Dalhousie University has a 16.1 million dollar campaign in progress, that a new Medical Building is one of the goals, and, more recently, that the Province of Nova Scotia has obtained the approval of the Centennial Committee to allocate a total of 5 million dollars toward the Sir Charles Tupper Centennial Memorial, half from the Federal and half from the Nova Scotia Government. All of these reports have created interest and all have raised very important questions in the Faculty of Medicine. Following a meeting of the Faculty in the early summer to consider the size of the new Sir Charles Tupper Building, a request was made by the Editor of the Bulletin for a report on that subject. Since this many-sided question involves an estimate of the need for doctors in the Atlantic Provinces, the trends in student enrolment, the growth in other training programmes in the health professions, the development of research programmes, the availability of teaching beds in the hospitals, and many other matters, I have decided to reactivate the "Dalhousie Notes" and have recruited some assistance to try to put them on a regular basis, at least as long as the editors wish to receive them. I hope they will be of interest to the doctors of Nova Scotia who have always been Dalhousie's strong supporters.

It is tempting first to look back over the past ten years and philosophize a bit. Perhaps, if space permits, that may come in a later issue. Suffice it to say that Dalhousie Medical School needed new quarters ten years ago. However, the newly-appointed Dean and his newly-established Faculty Council felt that the need for more staff, for more adequate salaries, and for a reorganization of the curriculum should have much higher priorities than new buildings. A greatly increased annual operating budget would be necessary to do all that we needed to do, and it seemed doubtful whether this could be obtained if we also asked for a large capital outlay. In 1954 the Provincial Government grants were very small. Except for the one from Nova Scotia, they had only started in 1947 and had not been increased. The total operating budget of

$350,000. was much less than that provided for other Canadian medical schools of similar size. The full-time teaching staff numbered only 16.

In spite of the crowding we are now experiencing, I think the right decision was made in 1954, but none of us thought that it would take ten years before we would have new buildings as well. By 1959 it had become amply clear that expansion was essential and the improved financial situation and increased staff made it more feasible than in 1954. However, it has taken five years to bring this dream to the point where plans are now being drawn. It will be three more years before the new Medical School Building will be opened. This slow gestation period should be kept in mind by those who are concerned with the development of the seven new medical schools recommended by the Hall Commission.

PRESENT BUILDINGS

As most readers know, the Faculty of Medicine is scattered through several buildings on the Carleton Campus of Dalhousie University. One of the greatest sources of weakness, in my opinion, is this fragmentation. Departmental barriers can arise all too easily in any institution but can reach serious dimensions when units are physically separated.

The Forrest Building, built in 1886, is shared by the Department of Biology of the Faculty of Arts and Science and the Departments of Anatomy and Microanatomy of the Faculty of Medicine. In addition, the Departments of Surgery and Physiology have research laboratories in this building.

During the past ten years space has been provided for some expansion of these Departments as the Law School, the Dental school and the International Fisheries Research Commission have moved from the Forrest Building. In addition, a large "attic area" was converted in the late 1940's into laboratories for the expansion of the Department of Biology. This Topsy-like growth has resulted in a "sandwich" within the building. Anatomy is on the ground floor and the research laboratories for Surgery; Biology is on the second; Microanatomy is on the third floor; and Biology on the top floor. In the basement there are various service rooms and student quarters for both Faculties and a research laboratory for Physiology. This arrangement is, to say the least, inefficient, but it is too costly to redesign this ancient building in order to transfer all of the laboratories and class rooms of one Department to adjacent areas. An even greater disadvantage is the large amount of waste space in the wide, high-ceilinged corridors and the excessively long, narrow rooms on either side of the corridor. Less than fifty per cent of the floor area of the building can be effectively used. The great fire hazard and the inadequacy of the water, electrical and sewage systems are other factors which limit the usefulness of this building. In some areas it is quite impossible to remodel the space because no more weight can be borne on the floors, or the system of piping will not permit the installation of any more laboratory sinks.

Unfortunately, with the rapid increase in student enrolment, it is unlikely that the Forrest Building can be demolished in the immediate future. It is so located in the very center of the campus that it is difficult to build another structure without crowding. However, the building has a limited period of life and usefulness estimated five years ago at less than fifteen years. It is not sensible to allow it to interfere too seriously with the proper placing of the new Medical School Building.

The Medical Sciences Building was constructed in 1922-23 and houses the Departments of Physiology, Pharmacology and Biochemistry. It is still in excellent condition and is a well-designed and well-constructed building. However, it was planned for an entering class of 60 medical and dental students, and for one professor in each of the three departments. It now serves 96 medical and dental students in first year and about 85 in second year as well as a very large number of students in the medical sciences and in the paramedical professions. The professorial staff in this building numbers 12, in addition to some 50 graduate students and technicians. Research facilities are extremely inadequate and it is impossible to obtain additional highly qualified teachers these days unless they are provided with adequate research laboratories.

It is intended that all Departments of the Medical School now located in the Medical Sciences Building and the Forrest Building will be moved to the new Sir Charles Tupper Building when it is completed. The space in the Forrest Building will continue to be used by the Department of Biology and the Institute of Oceanography until new quarters are provided for them. The Medical Sciences Building will be suitable for one or more of the schools which make up the Faculty of Health Professions, namely Nursing, Pharmacy, Physiotherapy, and Occupational Therapy. These are all now housed in temporary quarters and scattered over the two campuses.

The Dalhousie Public Health Clinic Building, which for many years housed the outpatient departments of all of the City hospitals, is gradually being converted into research laboratories for the clinical departments. The only outpatient clinics left in it are those for children. The adult clinics were moved to the Victoria General Hospital in 1948. The prenatal and postnatal clinics were moved to the new Grace Maternity Hospital in 1963. The Halifax Mental Health Clinic for Children was transferred to new quarters in the spring of 1964 in the Halifax Health Centre (the former Infectious Diseases Hospital). The Children's Hospital is planning an outpatient department in the new building now being planned.

The Public Health Clinic Building will then be totally devoted to research laboratories for the clinical departments of Medicine, Surgery, Obstetrics, Paediatrics, Psychiatry and other medical and surgical specialties. The lower floor has already been converted to research units for Medicine, Paediatrics and Surgery. The only clinical service remaining on that floor is the Students' Health Service. Half of the main floor was remodelled this summer, following the transfer of the Mental Health Clinic for Children. These new laboratories will eventually be used by the clinical departments when the Sir Charles Tupper Building is completed. They have of necessity been allocated temporarily to the Departments of Physiology and Pathology to relieve the over-crowding of the Medical Sciences and Pathology Buildings.

The Departments of Pathology and Bacteriology were provided with completely new teaching units when the Provincial Department of Public Health doubled the size of the Pathology Institute in 1961. The old teaching laboratories were remodelled for research. Already the service demands on these two Departments have increased to the point where there is pressure for more space. This increase in the laboratory service will become greatly intensified when the new Victoria General Hospital is completed. However, it has been decided by the University and the Provincial Department of Public Health that the integration of the service laboratories with teaching and research in the Departments of Pathology and Bacteriology has advantages

both to the Provincial Department and to the University. The teaching laboratories, the lecture rooms and the seminar rooms for medical and dental students will therefore remain in the Pathology Institute and some clinically-oriented research may be done there. However, new facilities will be provided in the Sir Charles Tupper Building for the basic research units of the Departments of Pathology and Bacteriology, for the education of science students, and for the courses given to the paramedical groups.

The Medical-Dental Library Building, opened in 1939, is already overcrowded and inadequate for the larger medical and dental student body. A larger medical library and reading room must therefore be provided. These will be in the new Sir Charles Tupper Building. The present building will be moved, if this is economically sound, and will be put to other uses not yet determined. It would for example be suitable for an auditorium or examination hall or as a large lecture room.

In addition to the existing departments there are several important areas of medicine which must be provided for. The growing and extremely important field of medical genetics must be developed. The biophysics and medical engineering areas are of increasing importance in medical research. Radiobiology, molecular biology, and several other important new fields of medical science have also to be provided with space for research and graduate training. There will also be disease-oriented research units such as those for cancer and cardiovascular diseases.

Accepting the fact that the present buildings are inadequate and must either be enlarged or replaced, the next question for the Faculty to consider was "How large a medical school should Dalhousie plan for?" In the next issue consideration will be given to some of the trends in student admissions, the number of teaching beds in the hospitals, and the growth in the number of students in other health professions, factors on which planning has been based.

September 28th, 1964. ■

A PHYSICIAN'S PRAYER

From too much zeal for the new; and contempt for the old; from putting knowledge before wisdom; science before art; and cleverness before common sense.

Good Lord Deliver Us.

MEDICAL LEGAL

The Medico-Legal Situation In Canada*

T. L. FISHER, M.D.

(Dr. Fisher, Secretary-Treasurer of the Canadian Medical Protective Association, gave the following address at a recent meeting of the Manitoba Medical Association)

The reason for my subject is the concern being caused our Canadian profession by the gloomy, fearful predictions appearing chiefly in American medical literature about our legal vulnerability. I suggest that this concern is unjustified in Canada. Because I am going to express opinions that I suspect many of you would doubt if they were unsupported, that fly counter to current opinion heavily concentrated in American medical literature and beginning to infiltrate ours, I am going to lay a foundation of fact first. Most of you will agree that statistics are boring, so I am going to give you immediately the few necessary for the foundation and I am going to ask you that you carry them in your minds.

Membership in the Canadian Medical Protective Association has increased since 1949-50 from 6,000 to 14,000; membership is 2-1/3 times as big as it was twelve years ago. These 14,000 members are drawn from a practising profession of 20,000 and this knowledge is important because it allows the reasonable inference that since the Canadian Medical Protective Association deals with the majority of medico-legal actions involving doctors in this country, certainly its experience must be greater than that of any other organization giving medico-legal assistance to doctors, and one might reasonably think its experience was greater than that of all the other organizations put together.

The Association divides into three categories the correspondence it receives from its members about matters which might end in legal actions against them: those letters asking advice; those reporting threats; those notifying the Association that legal action has been started. The first category may be larger than it otherwise would be, because the Association uses every reasonable means to encourage members to seek advice at the earliest possible moment after becoming aware that patients feel they have grounds for dissatisfaction. The number of doctors seeking advice about matters they considered serious, in 1949-50 was 53, in 1954-55 was 69, in 1959-60 was 96 and this past year it was 130. There is no need to remember all these figures; if you can, remember 53 and 130 and, in any case, remember the number of members who sought advice increased roughly 2½ times - about the same size increase as occurred in the membership. Needless to say the Association does nothing to encourage an increase in the next two groups. The number of doctors who reported threats against them, at the same time intervals was 52, 57, 51 and 77 last year - an increase of roughly one-half. The number of doctors who reported writs issued against them, at those same intervals, was 9, 13, 22 and 34 this last year - an increase of not quite four times. Annual figures, and comparisons of annual figures, do not give an accurate picture because there is an unpredictable variation from year to year but they are, nevertheless, indicators, I will restate these final figures so they may be easier to remember. Between 1949-50 and 1962-63 membership in the Association increased about 2-1/3

*Reprinted with permission from the British Columbia Medical Journal, June 1964.

times; advice was given to about 2½ times the number of doctors; threats increased by one-half; the number of writs increased something less than four times.

So much for figures.

All of you will have heard the old advice to a speaker that he should tell his audience what he is going to say, that he should say it, that he should tell them what he has said and then sit down; that is what I am going to do. What I am going to say to you today is that the legal position of doctors practising medicine in this country is not growing worse; that our Canadian legal profession is not making our road any rougher than we make it; that we get and can continue to expect just and fair decisions from our courts, adverse judgments when they have been earned and vindication when it is deserved; that the size of settlements and awards is increasing no faster than the value of the dollar is decreasing.

Now perhaps we can begin to take our subject apart and look at some of the pieces. Legal actions against doctors involve, directly, very few people. There has to be, first, a dissatisfied patient; there has to be a doctor whose work the dissatisfied patient thinks has been careless or negligent; there is a court, the arbiter. Here I should interject something too few doctors seem to realize. It is not necessary, for an action to be taken against a doctor, that the doctor has done something wrong; it is necessary only that some patient think the doctor has done something wrong. This needs to be clear in our minds.

Legal actions against doctors involve, indirectly, other people and other things, all of them essential if the complaint and the rebuttal are to be clearly stated. There is always a lawyer for the complainant, there is another for the defendant. There are involved rules of legal procedure designed to ensure the fullest, the most complete and the most accurate presentation of the complaint and of the defence to the complaint, and it is in conforming to these rules that many doctors become confused, often discouraged and sometimes resentful. Not uncommonly they feel that the whole business of refuting a complaint is so formalized and complicated as to obscure the issue itself. This I think is not true. A moment's thought will demonstrate that to us the confusing and complicated legal technicalities are not more formalized or complicated than the technicalities with which we necessarily surround much of our work and which so often seem to patients confusing and complicated. There is no doctor who, on many occasions, has not had to say to patients, in effect, that he cannot explain to them fully why he must do many apparently unnecessary things before he can take out an appendix, or treat a case of diabetes, or decide about the wisdom of cardiac surgery; he tells his patient these things are necessary, that they must be done if he is to do competent work, and he expects co-operation. We who, without legal training, sometimes can understand as little of the reason for legal technicalities as patients do for medical technicalities, should be perfectly willing to give lawyers all the help we can, should accept their advice and co-operate with them as wholeheartedly as lies within our power.

If you will accept my figures, and they are the best available, it will be apparent that the proportion of doctors with medico-legal actions against them is not increasing; proportionately the number of claims remains fairly steady, increasing about as fast as the rate of increase in the number of practising doctors.

One reason for this is the people for whom we work, our patients. There can be little doubt that Canadians, at least in medico-legal matters, are not

litigious people. There must be many occasions when patients fail to understand incomplete recoveries or unexpected disabilities, yet they trust their doctors and accept their explanations and seldom call them to account in court. Our people seem not to think that way.

Our patients seem to assume that doctors will do their best without any legal goad, and doctors hold it a privilege and duty to give their best without the goad. There is no need, with this audience, to develop this point.

The Association is constantly reminded of the truth of the next point: the legal profession is not making our road any rougher and is not trying to do so. The ethics of the legal profession are as high as our own and preclude taking any unfair advantage of any group or profession. Were this not so our situation might be vastly different. We might be forced, every time we treated a patient, to think first of ourselves, to consider how best to apply treatment to protect ourselves in case of failure, instead of being, as we can be, single-minded in doing those things we think are best for our patients. As an example of what might be: in the United States, whence emanate many of the gloomy medico-legal predictions that depress us needlessly, we understand that it is ethical for lawyers to work on a contingency fee basis; in Canada the contingency fee, like fee-splitting with us, is unethical and this difference in ethics may be a significant factor in determining a suit in a marginal case.

Our courts are fair and impartial, and that statement can be made flatly, without any comparisons or comparatives. We all know it. We know it so well we seldom say it. The knowledge removes some of the sting of an occasional bitter defeat; we know that, whether or not we think a court decision was right, nothing influenced it other than a desire to adjudicate fairly. That we recognize the fairness and impartiality of our courts must not be interpreted to mean that our courts are more lenient with one than another group, more lenient with us than with any other group. That would be untrue. Our courts are quick to show they do not condone poor work and quick to award what they consider adequate damages in the event that a patient suffers from poor work. But by the same token, they do not make an award for something that could not have been prevented.

Then, too, our laws, and the manner of their application, favour impartial and objective judgments. In the United States, for example, many medico-legal actions are tried by juries. The problem with juries is that, with the best of intentions but being laymen skilled neither in law nor medicine, they may not fully comprehend the medical evidence, and may not apply legal principles to reach a decision; they may get carried away by sympathy, they may be influenced by the resulting loss from an obvious injury not caused by the doctor they may lose sight of their primary function which is to ascertain if the doctor's work was poor.

In Canada, in some jurisdictions, malpractice actions are tried by juries, but this tends to be an exception to the general rule. In most of our Provinces provision is made whereby complicated and technical matters which might be confusing to an untrained person are heard by a judge without a jury; although a judge may sympathize with a plaintiff, he, nevertheless, will not make an award on sympathy but only if there is a sound legal basis to impose liability. In our opinion this is a significant safeguard against an inflationary trend and against judgments out of proportion to the injury suffered.

Juries do not give reasons for their awards so if there is a mistake there is no way it can be easily undone, whereas if a judge makes a mistake and proceeds

upon a wrong principle it can be corrected in a Court of Appeal. In our experience, incidentally, few such mistakes are made by trial judges.

In malpractice actions the onus of establishing liability is on the person who claims the doctor has been negligent; there is a deal of difference between having to rebut evidence that you were wrong and having to prove you were right.

The last point I wish to make is that our Association sees in Canada no evidence that the size of settlements that have to be negotiated, and the size of awards made by courts, are becoming disproportionate to the damage that has been done. The amounts necessary for settlements and the amounts awarded by courts have increased in the last decade or two; they have perhaps doubled or a little more. For example, I can remember when the recovery of a sponge or a haemostat from an abdomen, granted there was no damage to the patient aside from the need for another operation, and that there were no complications, cost less than $2,000.00. Gradually, the cost rose to perhaps $2,500.00, then $3,500.00 and the figure is little above that now. The size of settlements or court awards has increased, that is, to about the same degree that the cost of most other things has increased or that the value of the dollar has decreased. Our courts do not make awards on a basis of maudlin sentimentality, they are realistic and as far as possible make the doctor pay for the damage he did, and not for the damage done by the original injury or illness.

Finally, we have in Canada one other advantage which on this continent is enjoyed by Canadians alone. We have a mutual medical defence union to which the majority of practising doctors belong, which is operated on the principle that every defensible claim against a doctor will be defended. There are no settlements of claims merely because they have a nuisance value. One result has been that people know they cannot force a settlement by the mere threat of proceedings against a doctor.

There is one interesting side result of this policy. For years, for decades, the Association has been told by others, it has been told by an occasional member, that it was foolish to be willing to spend two or three or four thousand dollars to fight a case that could be settled for two or three or four hundred dollars. The Association, nevertheless, felt that in the long run this policy was correct and it has proved to be so. If there are those of you who doubt it, remember that membership in the Association, which makes you eligible for whatever medico-legal assistance you may need, costs you only $20.00* a year whereas insurance to provide the same help probably would cost more and in the United States where, for their own good reasons, settlements are made often and easier, insurance premiums vary from $100.00 to $600.00 a year.

Gentlemen, I have now come to the place where I can sum up what I have just said. Our people are not litigious; our profession is conscientious; our legal profession is ethical; our courts are fair and impartial; the awards by our courts are realistic; there is in Canada a mutual medical defence union that operates from the principle that the doctor in trouble will get the best help possible given in a way that will be least harmful to the profession as a whole. If you will add all these things together, you will realize that the medical profession in Canada is fortunately situated. Its fate medico-legally remains in its own hands; there is no reason to think it will be more legally vulnerable than it is now if doctors continue to provide scientific, competent, personal and kindly care to their patients. ■

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*This fee has since been reduced to $15.00 a year.

BUSHVELDT VIGNETTE

3rd week in June: 1964

Dr. W. Sidney Gilchrist

Dear Friends: -

That is friends on the General Letter list,
most of whom deserve something better than a general letter,
but some of whom don't deserve even that!

Operation "Hanging On" continues. We have no plan, so it can't go according to plan. So we play it by ear which is all right, only some of us are getting old and deaf!

If Roy Webster (secretary of the World Missions Board of the United Church of Canada) and Chester Marcus (secretary of the U.S.A. Board of World Ministries of their United Church south of the border) had gotten in to talk with us this week as planned, maybe between us all we'd have come up with a scheme for handling an impossible situation. But they weren't allowed in.

There are 5 missionaries of the American Board left. There were normally more than 30. A few years ago we had more than 30 Canadians, too, but when the Knights and MacInneses leave very soon we'll be less than 20. We hope that Strangways may get back without hindrance. That will help. As for Frankie and myself, we shall soon be into our eighth year.

A recent visit from the Canadian ambassador in the European metropolis did not bring us assurance of better days ahead.

In the meantime, we do our little bits for our concept of the Kingdom which of course means, among other things, reconciliation, brotherhood, one-ness, interdependence between individuals and groups, without which all will be lost here and everywhere else. You are just as much "on the spot" *there* as we are *here* although it may not yet be so apparent.

In the doing of our mites of service and witness, there are, more than ever before, obstacles, annoyances, injustices, grievous misunderstandings and lurking dark spectres of horror. We try not to magnify them.

We rejoice in your support and rapport, your letters and prayers, and your enlightened concern and study of the African situation. You are lucky, you know, for you can get unbiased reporting from various reliable sources whereas

many who are nearer to the situation (and right in it) cannot see the woods for the trees and rely only on spoon-fed information.

The path ahead seems to lead on into the darkness but we are not prophets - only workers.

I think I speak for everyone of us when I say, *How dear to our hearts are this land and all its people*! How we yearn for its peace and progress! After all these are normal human feelings and longings for folks who've spent the better parts of their lives here! . .We're at the coast, as I write, 350 kilometers away from base. On Sunday morning, with Carl (an American missionary), I slipped into a seat in the crowded African church on the mud-flats. A 14-year old girl, four rows to the front, looked around and her face lit up with the welcomingest smile you ever did see! And that was just the first of many other messages of love she flashed at me before the service was over. Now, like every other senior missionary, I receive many smiles and nods and greetings in many places in quite a large corner of Africa. Some of them are old people and some are youngsters. Some of them I brought into the world. Many of them I can't name or place, for we have worked in various parts of Angola. But this young Sunday-morning lady I *know*. She was just a wee skinny lassie with a badly crippled spine when she came to us in Dondi a good many years ago. And look at her now - strong and happy and lovely . . . . .and smiling at ugly old me!

The day before at the bus stop I met a white Portuguese doctor. We embraced each other. He and I had been class-mates at the School of Tropical Medicine in Lisbon 35 years ago. On the streets of this little city where, after all, I am a stranger, scores of Africans stop to shake hands and not a few whites do the same. (I feel a litle scared when I think of wandering down Yonge Street in Toronto or even Barrington Street in Halifax and perhaps not meeting a soul who will know me or whom I will recognize!)

There are the little cemeteries in the high plains of the hinterland where three of our African-born children lie buried; three out of five.

There is our only daughter who, as I write this, is the only missionary on a remote mission station in the South of Angola; with her 23 orphaned babies, her great school for girls, her manifold educational and evangelical activities, and her deep love for the African people with whom she enjoys a unique rapport and kinship relation. Time and again I have heard African pastors and elders refer to her as "our daughter".

There is the hospital up country which we have had to leave for a few days to come here to the coast. There are some 500 patients there in the sick camp, the maternity centre, the tuberculosis sanatorium "We Sing; Not Cry", the leprosarium and the hospital proper. The total distance they have travelled - much of it on foot - would be more than 5000 miles!

There are the nurses who *perforce* have to be part-doctor as well. The helpers, the 80 rural midwives who deliver more than 1000 babies a year, the 15 rural health posts with their medical aides who are healers and teachers and technicians of Disease Prevention and Positive Health.

When we missionaries find ourselves completely "wound up" in and overburdened with the work, we accuse each other of suffering from "missionaryitis". But how can we be other than tremendously anxious, concerned and even apprehensive?

How long *can* we hang on? When will new workers get here, be trained, be ready for service? (Remember we had more than a score of African students in the universities getting ready for the work a few years ago. They are

scattered now). (Remember too, that Protestant missionary work has practically ceased in all other areas of Angola)

I believe that the home churches must find the answers.

Let them not give up. Let them not flag or fail now *of all times*! Let them not forget that tomorrow is Africa's Day!

Do we *want* to see a Christian Africa? Not an American or a European Christianity in Africa but an African Christianity in Africa?

Part of the answer must be given by you and those like you in the Protestant churches of Canada and U.S.A.

It is four years since Max Warren wrote, "In Africa everyone knows that there is a desperate race against time, that time is the great enemy". That statement is four years more true to-day!

Sincerely,

Sid

Missao Evangélica do Bailundo
Vila Teixeira da Silva,
Angola

FROM THE BULLETIN OF 40 YEARS AGO

From The Medical Society of Nova Scotia Bulletin, December 1924.

Organization of the profession in Nova Scotia, compared very favorably with other provinces. There are about 380 doctors in Nova Scotia in practice who might be regarded as eligible for membership in the Provincial Society. Over two hundred are fully paid up members of whom 140 are members of the Canadian Association as well. Nova Scotia has a larger proportional representation in the Canadian Association than any other province. It has been pointed out that the success of a Provincial Society will depend upon the coordinating of the activities of its Branches. The local societies form the arch supporting the structure, and fault or weakness of any part endangers the whole. (1) It is beneficial to the doctor on social grounds, his associates will be recognized as colleagues and not competitors. (2) Frequent attendance upon Society Meetings improves the doctor's standing in the community, no doctors today can afford to get the name of not attending medical meetings. (3) The people have more confidence in these doctors and it makes a close, more influential and more profitable relationship between the doctor, the public generally and individually. (4) This greater intimacy will clearly convince the people of the altruistic aims of the profession today; not more than in former years, but markedly so in view of the general materialistic tendency of the present day. (5) The advantages from scientific discussions are obvious. (6) The small society is a trainer and feeder for the larger society, so that doctors may acquire confidence before their colleagues. (7) The local society is a medium through which leaders in the profession may present results of their experiences to the general practitioner. (8) Through the local society the profession can best identify itself with the public in all matters of community welfare; and expression of this interest is essential if we are to hold the confidence of the public, which is now so generally concerned in questions of health.

Extract from the address given by the Associate Secretary of the Medical Society at the Annual Meeting of the Cape Breton Medical Society, October 1924.

Treatment of Congenital Malformation of the Ear

It has been estimated that in one of approximately 750 births there is a congenital malformation of the upper lip or the palate or both. Another type of developmental failure that seriously mars a person's physiognomy is a malformed external ear, which at times results in microtia, or a diminutive external ear, or more often presents itself merely as aural tags of varying size that have hardly any resemblance to a normal ear.

Such developmental arrests, although not as common as a cleft palate or a cleft lip, nevertheless are conditions that are frequently seen by the physician and especially by the plastic surgeon or the otolaryngologist. The presence of this deformity becomes an immeiate concern to the parents when the child is born and an even greater concern to the patient as he or she grows older and becomes aware of the social handicap it creates.

Reconstruction of such auricular malformations has been and still is a challenge to the skill of the plastic surgeon and an intriguing technical procedure to the maxillofacial prosthetist.

A paper by Bulbulian and Litzow (Proc. Staff Meetings Mayo Clinic, 36:429, 1961) calls attention specifically to a practical advantage that can ensue from a collaborative effort between the plastic surgeon and the maxillofacial prosthetist in the satisfactory management of such malformations.

In the majority of such cases the main objective of the restorative procedure, namely helping the patients overcome their self-consciousness and embarrassment, can best be attained through such a combined effort.

CATEGORIES OF MALFORMED EARS

Malformed ears for the restoration of which a collaborative effort of the plastic surgeon and the prosthetist is indicated may be classified somewhat arbitrarily in three general categories.

Category 1 includes those malformations with aural tags that appear unlikely to be utilizable from a plastic surgical standpoint. Nor does there seem to be any advantage from the standpoint of a prosthesis, in allowing any of these aural tags to remain, since they are as a rule located in such positions that they interfere with building up of a normal-shaped external ear over them. In addition, the developmental arrest usually involves portions of the middle ear to such an extent that corrective surgical intervention in this region is also contraindicated.

Under this set of circumstances a carefully planned amputation of the aural tags with the objective of producing the best possible foundation for an eventual prosthesis is a sound approach to the problem. The postoperative contour thus produced at the site of amputation, its location, and the type of scar formed should be of such nature as to enhance rather than hinder the end result of the prosthesis from an esthetic as well as a retention standpoint.

In all such cases the plastic surgeon should obtain sufficient preoperative measurements that have a bearing on the particular requirements of the prosthesis before proceeding to remove the aural tags. To help him to do this, preoperative casts of the deformed ear as well as of the normal ear on the opposite side are very helpful when these are used as preoperative study models. The proposed line of incision as well as the end result with the prosthesis in place can be more readily visualized with the aid of such preoperative replicas.

Category 2 includes those malformations that are confined to the pinna and portions of the auditory canal. The middle and inner components of the acoustic apparatus are sound, thus suggesting a possibility of improving the patient's hearing by plastic reconstruction of the canal and the external meatus. Feasibility of such a procedure, that is, creation of a patent auditory canal, should be investigated by a competent otolaryngologist in consultation with the prosthetist in all such patients who are considered likely candidates for a prosthetic ear.

Such a preliminary plastic procedure for the external meatus if successful, will not only help the patient's hearing but will also produce a condition that is bound to be useful from the standpoint of the prosthesis. For example, the newly established external meatus would impart to the prosthesis a more natural appearance and furthermore would provide a very effective means of retaining the prosthesis in correct position and add to its stability. Attainment of these two favourable conditions often will make the difference between a successful prosthesis and an unsuccessful one.

Category 3 includes those congenital malformations with some useful aural cartilages that by proper reshaping or reshaping and transferring to another site, can be made to become very useful components of the prosthetic ear, for example a built-up tragus.

The tragus, the somewhat flattened, roughly pyramidal structure whose apex is directed toward the external meatus, is an outstanding example of such useful component which can often be reconstructed by a plastic surgical method.

The minimal age at which it seems feasible to undertake a prosthetic reconstruction of the type described in this paper is an important consideration. In general, it is best to wait until the child is old enough to be able to cope adequately with the care and application of the prosthesis. We believe that it is not advisable to attempt a prosthetic restoration before the patient enters high school. Participation in certain types of athletic activities may necessitate further postponement. Other considerations such as patients' ability to be socially well adjusted in spite of deformity will no doubt influence the decision. Each case has to be evaluated according to the situation present. ■

The Grenfell Mission
Medical Opportunities

The Grenfell Mission is opening a new hospital in Happy Valley, Labrador. It **urgently** requires a Medical Officer and an Assistant Medical Officer for this twenty bed general hospital. The building, which cost over a million dollars, is perhaps one of the finest cottage hospitals in existence, and the equipment is exceptional.

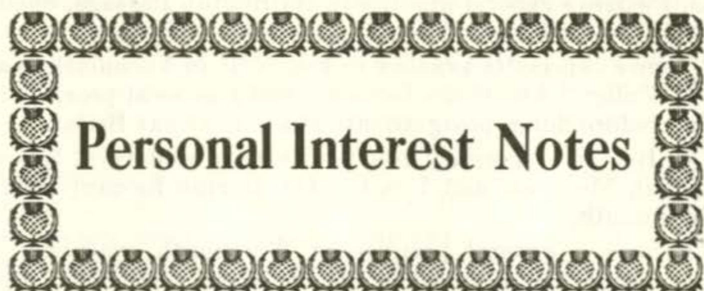
The Medical Officer in Charge will receive a salary of $12,000 per year and in addition an extremely comfortable modern house, heated, lighted and completely furnished. He would be permitted to buy some of his supplies from the Grenfell Mission at favourable rates. A mileage allowance for his car is provided. He would be in charge of the hospital, which is chiefly a medical job. Administratively he would receive supervision of the hospital accounting, supply, inventory etc. from the senior hospital in the medical district, the forty bed hospital at North West River and administrative duties should not be difficult for him. Primarily a medical post, the candidate should be able to do simple emergency surgery such as appendices, or Caesareans, although help would be available to him as a rule if required. More surgery could be undertaken if qualifications permitted.

The Assistant is offered a salary of $8,000 per year. He would live in, unless special provisions were requested for married quarters, and would pay fifty dollars per month board. Spacious and comfortable quarters provided. If married, quarters could be found for him at nominal charge. Mileage allowance etc. as above.

The senior position would require either good training or a small amount of experience in practice, the junior one would require no more than an MD and perhaps a year of interneship. The hospital would work very closely with our nearby hospital at North West River both medically and administratively. The positions offer unusual opportunities for medical responsibility and the complete management of many types of cases, and would be of particular value to those interested in rural general practice. The surrounding country is unusually beautiful and offers much of interest to the adventurous. For interested staff there would be considerable opportunity for flying around Labrador and there are opportunities for hunting and fishing. The work is strenuous at times, but paid vacations are provided.

The community, on the perimeter of Goose Airbase, consists of about five thousand persons, and has good shopping and other facilities rarely found in Northern communities.

Application can be made to the Grenfell Labrador Medical Mission, 88 Metcalfe Street, Ottawa, or by applicants in the Halifax area to Dr. W. A. Paddon, MD., DPH, care of this journal, who will be in Halifax for several months.



From New York City to Membertou, from Yarmouth to Sydney come notes of interest for the Bulletin. Thank you and please keep the leaf turned over.

Cape Breton Medical Society

Our apologies that our correction was not completely correct.

Dr. Tremblett **is not** the pathologist for St. Rita's Hospital. **Dr. Alex Gyorfi is the pathologist for St. Rita's Hospital, Sydney.**

The pathologists for the other hospitals in Cape Breton are:
City Hospital, Sydney: - Dr. Robert Mathieson
St. Elizabeth Hospital, N. Sydney: - Dr. Tremblett
Harborview Hospital, Sydney Mines: - Dr. Tremblett.

C.B. North Pre-school Indians

A tuberculin survey was carried out among the pre-school Indian population of the three Reserves in the Cape Breton North Health Unit in cooperation with the public health nurses of the Dept. of National Health and Welfare, Indian Health Services, through the courtesy of Dr. P. Kelly. The last B.C.G. program was carried out in 1958. The three Reserves tested were Membertou, Nyanza, and Eskasoni. These pre-school tests show a total of 219 negative and two positive reactors, (Eskasoni).

Halifax Medical Society

The Halifax Medical Society held its Semi-Annual Dinner meeting on October 14th at the Lord Nelson Hotel. Guests at this meeting were the president of The Nova Scotia Medical Society, Dr. Tom Gorman and also the President-elect, Dr. Tony Griffiths. The best attended meeting in recent years heard a fascinating discussion by Dr. Tom Casey about his experiences in Medical Practice in Nigeria.

Western Counties

Additions to medical group in Western:

Dr. Mike E. DeLory - surgical practice in Shelburne.

Dr. A. J. Lupin - general practice in Tusket, Yarmouth Co., replacing Dr. Wm. Mason who has gone to Halifax for postgraduate study.

Dr. J. MacWilliam - general practice in South Ohio, Yarmouth Co., replacing Dr. B. Auld who is doing postgraduate study.

Dr. R. G. Pledges - general practice in Barrington Passage, Shelburne Co., replacing Dr. G. Imrie who has taken up a practice in Ontario.

Dr. I. F. Bruce - specialty practice in E.E.N.T. in Yarmouth in association with Dr. C. K. Fuller. Dr. Bruce formerly had a general practice in Hebron, Yarmouth Co., before doing postgraduate study in Great Britain.

Dr. G. V. Burton - specialty practice in Obs. and Gyn. following postgraduate study in Montreal and U.S.A. Dr. Burton formerly had a general practice in Yarmouth.

Dr. B. Erjavec - general practice in Weymouth, replacing Dr. H. J. Pothier, who has retired and moved to Beaver River, Digby Co., where he still carries on a small amount of general practice. Dr. Erjavec formerly practised in Louisdale, C.B.

Dr. J. H. L. Robbins who has had a general practice in Lockeport since about 1950 has accepted a position with the Department of Veterans Affairs, Halifax.

Dr. M. T. Cooper has moved from Clark's Harbour to Shelburne to continue in general practice. He is now associated with Drs. W. H. Jeffrey and D. R. Campbell in a group practice known as the Shelburne Medical Group. These three men are full partners in a clinic to serve Shelburne and surrounding district beginning July 1, 1964.

Dr. W. C. O'Brien - has opened a practice in Wedgeport, the place he practised in years ago. For many years he has practised in Yarmouth town.

Dr. Gordon R. Hennigar, a Dalhousie graduate of 1945, has been appointed Professor and Chairman of the Department of Pathology, Medical College of South Carolina, Charleston, South Carolina. Since 1957 Dr. Hennigar has been Professor of Pathology at the State University of New York and Supervising Pathologist of the Institute of Pathology, King's County Hospital Centre, Brooklyn. He will assume his duties in January and will be accompanied by his wife. (June King) and their five children.

"It's a long way from Vimy Ridge to Noel Shore but Dr. Hines was there and back," is the title of Medical Flashback in the Chronicle Herald of October 30, 1964. "Any doctor who ever practises along the Avon shore in Hants County will know that the life is not an easy one," is the opening sentence. Dr. Arthur Hines, who graduated from Dalhousie in 1916, after being medical officer of various units in the First World War and winning the Military Cross, came back to the Cogswell St. Military Hospital, Halifax, and from there, in the fall of 1919 took over the practice of that well known doctor, his aunt, Dr. Annie Hennigar Sanford on the Noel Shore. There, through fair weather and foul, he served his farflung community until 1952 when his practice was taken over by his son, Dr. Charles Hines.

Dr. Marjorie Smith, who carries on a busy general practice in Spryfield as a partner to her husband and classmate, Dr. Kevin Smith, reports that she lectured at their class (1954) reunion this summer, that all **five** women who graduated at that time are engaged in active practice. That's an answer to "Why let a girl take the place of a man applicant for med school? She will only drop out or get married or not practise? WELL! These five are all married **and** practising.

The Federation of Medical Women, Nova Scotia Division, held their Fall meeting recently at the home of the President, Dr. Jean Lawson. The women medical students at Dalhousie were the guests, especially the five first year students who were welcomed by Dr. Lawson. Planning got under way for the meeting of the Canadian Federation which will be held in Halifax next June in conjunction with the Canadian Medical Association Annual meeting of which the Federation is now a member. Dr. Helen Hunter showed her collection of beautiful coloured slides taken last June at the meeting of the International Federation meeting held in Norway. She and Dr. M. Rostocka, Wolfville, were two of the ten Canadians present at the meeting.

Births

To Dr. and Mrs. John Barteaux, (née Elizabeth MacCallum), a daughter, Penny Lou, at the Grace Maternity Hospital, on October 16, 1964.

To Dr. and Mrs. O. H. Horrelt (née Betty Morrison), a son, Mark Otto, on September 27, 1964, at Dawson Memorial Hospital, Bridgewater, N. S.

To Dr. and Mrs. Emerson MacRae (née Dorothy Oliver), a daughter, Leslie Koren, at the Grace Maternity Hospital, on October 11, 1964

Obituaries

Dr. Ronald Roderick Sutherland, a well known Yarmouth doctor and veteran of two world wars died in Camp Hill Hospital, Halifax, on October 17. He had suffered a stroke earlier this year and had returned from his home to Camp Hill only a week before his death. He practised in Tusket, Yarmouth County from 1925 to 1929 and the for ten years in Middle Musquodoboit, returning to Yarmouth County after serving during the second World War in the Medical corps. He operated a general practice in Yarmouth until 1956 when he took a course in Optology and then returned to Yarmouth where he practised until taken ill.

DOCTOR WANTED

Due to the recent sudden death of Dr. Harry S. Smith, the community of Caledonia, Queens Co., urgently requires the services of a general practitioner. Please contact Mr. Donald R. Benedict, Pres. Board of Trustees, North Queens Cottage Hospital, Caledonia, or The Medical Society of Nova Scotia.

Only Nova Scotia Has Charter Flag

(Chronicle-Herald)

Nova Scotia is the only province of Canada to possess, through Royal Charter, a flag of its own.

The flag of Nova Scotia traces its origin to the Charter of New Scotland, granted to Sir William Alexander in 1621.

In 1621, King James VI of Scotland, who was also James I of England, granted Sir William all the lands lying between New England and Newfoundland for the formation of a colony.

The colony was to be called New Scotland, or, the Latin translation, Nova Scotia.

Sir William's attempt to colonize Nova Scotia in the early 17th century was a dismal failure.

Under the powers conferred on him, he divided the colony into tracts of land which he was ordered to grant "to all such principal knights and esquires as will be pleased to be undertakers of the said plantation and who will promise to set forth six men, artificers or laborers, sufficiently armed, apparelled and victualled for two years.

In 1629 the first group of settlers, 70 in all, arrived in Nova Scotia to attempt colonization.

They established a settlement known as Scots Fort, but suffered severely during the first winter. Thirty of the colonists died during the winter, and the fort was demolished in 1631.

The project of Sir William Alexander was thus a complete failure, but it left Nova Scotia with the right to display its own flag.

The flag is derived from the Royal Coat of Arms given to the colony in 1625.

The flag is a silver field with a blue St. Andrew's cross, a small shield with the royal arms of Scotland in the centre.

The shield is gold, a lion rampant red, with teeth, claws and tongue blue. The lion is placed within a double tressure which is red.

The colorful flag, with its equally colorful historic background, is a common sight for the Nova Scotian and an interesting feature of the province for the out-of-province traveller. ■

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