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MEDICAL MANPOWER

A Saskatchewan Viewpoint

In the January 6, 1973 edition of the Canadian Medical Association Journal, M. A. Baltzan, M.D., C.M., of the Baltzan Associates Medical Clinic in Saskatoon, Sask., took a penetrating look at medical care costs in relation to physician manpower.

Dr. Baltzan explored and discussed the following questions: 1) What is the relationship between physician net income and the cost of physician services? 2) What is the relationship between the number of doctors per capita and the per capita cost of physician services? 3) What is the relationship between the mean price per service and the mean number of doctors per capita? and 4) What is the relationship between physician services per capita and the number of doctors per capita?

In exploring and analyzing data based on Canadian experience in the delivery of physicians' services, Dr. Baltzan noted that the following elements were strongly suggested:

a) The cost of these services is not related to the income of physicians.

b) The cost is directly related to the number of doctors.

c) Price per service is also related to the number of doctors.

d) The volume of services received by the public is also related to the number of doctors.

e) The number of services per doctor does not progressively increase after the removal of financial barriers to access and is not diminished by the reintroduction of a small direct charge to the patient.

Dr. Baltzan stressed that these observations were not anticipated, although, of course, some might hold them to be self-evident. But how does this relate to cost control and the maintenance of quality service?

Dr. Baltzan says: *"Additional analysis leads to the suggestion that the most logical way to control escalating costs without impairing quality or quantity of service is to avoid excessive numbers of physicians and to ensure that the payment mechanism stimulates the highest possible number of services per physician with due regard to quality".*

Once again, for the complete story the Bulletin refers you to the Section on Economics, the Canadian Medical Association Journal of January 6, 1973.

And, naturally, we would welcome your observations on this question. □

Medical Manpower in Nova Scotia*

C. B. Stewart,** M.D.

Halifax N.S.

A report on medical manpower has been presented to the Nova Scotia Health Council[1]. A brief summary of the major findings and the supporting tables may be of interest to readers of the *Bulletin.* The methods and sources of data will not be summarized but acknowledgement is made of the valuable assistance of the officers and members of the Medical Society of Nova Scotia.

It has been customary to present statistics on medical manpower as a ratio, showing the average population per physician. This is usually based on the total number of licensed physicians in province or country, divided by the population. Rosenfeld and Simms[2] reported that Nova Scotia had 1,123 physicians, or a ratio of 1 registered physician per 685 people. They concluded that this was adequate. The World Health Organization recommends at least one physician per 600. In the following series, Tables I and II show that there were 1,185 physicians in Nova Scotia in January-February, 1972. Only 870 were in full-time practice in clinical or laboratory specialties devoted primarily to patient care. An additional 233 were in part-time clinical practice, most of them with additional responsibilities in medical education, research or administration. The estimate of full-time clinical equivalents was 1,030 physicians, including 182 in residency training. Estimates of the time devoted to clinical practice on which physician-equivalents were based, were made by local members of the Branch Medical Society with a fairly accurate knowledge of the practitioners of the area. While these estimates are subject to a certain margin of error, data on physician-equivalents give a more accurate picture of the medical manpower providing patient care.

Table III shows the ratio of population per physician based upon the total head count and also on full-time equivalents. The crude ratio of 1 physician per 666 persons is changed to 1 practitioner per 766 persons if residents in post graduate training are included, or 1:930 if based on the full-time equivalent for general practitioners and specialists. The ratio is 1 full-time general practitioner-equivalent per 1,947 persons and 1 specialist per 1,781 persons.

Table IV shows the regional distribution of the general practitioners. The largest ratio, or the lowest supply of physicians, is in Cape Breton Island and the three Western Counties. Although it has frequently been stated in recent years that the number of family physicians in Halifax and Dartmouth is inadequate, the actual ratio of general practitioners in the two cities and Halifax County is the best in the province. Other regions that have a better ratio than the provincial average are Colchester County, Lunenberg-Queens, Pictou and Cumberland. However, the report warns against jumping to the conclusion that a ratio which meets either the Provincial or Canadian average is necessarily adequate.

TABLE I

NUMBER OF PHYSICIANS IN NOVA SCOTIA, 1972

	General Practice	Specialists	Total	Post Grad. Residents	Total
Clinical					
full-time	392	297	689	182	871
part-time	23	210	233	–	233
Total	415	507	922	182	1,104
Non-clinical	–	–	–	–	37
Retired or Inactive	–	–	–	–	41
Unclassified	–	–	–	–	4
Total	–	–	–	–	1,186

TABLE II

ESTIMATE OF FULL TIME CLINICIAN EQUIVALENTS

	Total Number	Full-time Equivalents
General Practitioners	415	405
Specialists	507	442
Total Practitioners	922	847
Residents	182	182*
Grand Total	1,104	1,029

*including post-graduate education

*An abstract of the Report to the Nova Scotia Health Council.

**Vice President (Health Sciences), Dalhousie University, Halifax, N.S.

Tables V and VI show the heavy concentration of specialists in Halifax-Dartmouth and Halifax County, even when correction is made for the fact that a considerable number are in part-time clinical practice. This is to be expected since the Provincial referral hospitals and Dalhousie Medical school are located in Halifax. The tables show other regional differences which are also of interest.

Table VII shows the distribution of specialists by specific fields of practice and compares the Nova Scotia ratio with the Canadian average. The Nova Scotia ratio for all specialties is 1:1,785 persons and the Canadian average is 1:1,746. Again, the Report warns that meeting the Canadian average does not necessarily establish the adequacy of the supply. In radiology, general surgery and pathology-bacteriology, the Nova Scotia ratio is better than the Canadian average. In the other fields it is slightly lower.

The ratios for both general practitioners and specialists have improved significantly during the past 20 years.

The Report emphasizes the need for the medical profession to establish national standards of adequacy for general practitioners and specialists in each of the fields, rather than depending upon a comparison of the ratio in one area or province against a national average, which itself may be deficient.

The Report also provides information on the number of post-graduate trainees by specialty. The number of part-time physicians by percentage of time in clinical practice and the number in solo or group practice are shown in Table VIII. Of the 450 general practitioners 160, or almost 40%, are in organized groups or practising in the same building with other doctors, arrangements that might include a Community Health Nurse.

TABLE III

POPULATION PER PHYSICIAN

	Population per Physician	
	Based on No.	Based on equivalents
General practitioners	1,901	1,948
Specialists	1,556	1,785
Total practitioners	856	931
Total practitioners and residents	715	767
Total registered M.D.'s	665	–

TABLE IV

REGIONAL DISTRIBUTION OF GENERAL PRACTITIONERS

Region	Number of General Practitioners		Clinican	Population Per Full-Time
	Full-time	Part-time	Equivalents	Equivalent
Hfx-Dtmth, Hfx. Co.	148	14	156	1,676
L'berg-Queens	28	1	29.6	1,736
Digby, Shel., Ymth.	29	1	29.5	2,091
Valley-Hants	46	0	46	2,082
Colchester	21	1	21.5	1,755
Cumberland	18	2	18.6	1,890
Pictou	24	1	24.6	1,874
Antig.-Guys.	14	0	14	2,120
C.B. Island	64	3	66	2,576
TOTAL NOVA SCOTIA	392	23	405.	1,948

TABLE V

REGIONAL DISTRIBUTION OF SPECIALISTS

Region	Number of Specialists		Clinical	Population Per Full-Time
	Full-time	Part-time	Equivalents	C-E
Hfx-Dtmth, Hfx. Co.	123	194	261.3	1,001
L'berg-Queens	15	2	15.6	3,293
Digby, Shel., Ymth.	21	1	21.9	2,817
Valley-Hants	34	1	34.5	2,775
Colchester	15	1	15.3	2,466
Cumberland	5	0	5	7.032
Pictou	14	0	14	3,293
Antig.-Guys.	11	0	11	2,698
C.B. Island	57	11	63.5	2,677
TOTAL NOVA SCOTIA	297	210	442.	1,785

TABLE VI

REGIONAL DISTRIBUTION OF SPECIALISTS BY LARGER REGIONS

	Population per Full-Time Specialist
Hfx, L'berg-Queens.	1,130
Digby, Shel., Ymth.	2,817
Valley-Hants	2,775
Colch-Cumb.	3,591
Pictou-Antig-Guys	3,031
Cape Breton	2,677
NOVA SCOTIA	1,785

It is concluded that there is not as great a shortage of physicians in Nova Scotia as is sometimes suggested as compared with the national average, but doubt is thrown on the latter as a valid measure for comparison and for future planning. □

References

1. **Stewart, C. B., and Benjamin, J.:** Medical Manpower in Nova Scotia. Report to Nova Scotia Health Council, February, 1973.
2. **Rosenfeld, G. B. and Simms, G. G.:** Report on an Integrated System of Hospital Facilities and Related Services, Nova Scotia, 1971, 93 pp. and appendices.

TABLE VIII

WORK SITUATION OF GENERAL PRACTITIONERS AND SPECIALISTS

	Number of G.P.'s	Number of Specialists	Total
Solo Practice[1]	219	194	413
Group Practice[2]	160	94	254
Military[3]	7	7	14
Public Health[4]	0	7	7
Hospital[5]	21	159	180
University[6]	8	59	67
Other – Gov't., etc.	4	3	7
Non-Clinical and inactive	28	31	59
Unknown	3	0	3
TOTAL	450	554	1,004

[1] All solo practitioners, full-time or part-time, including any combination of solo with hospital, clinic or university.
[2] All group practices including any combination of group with hospital, university or public health clinic.
[3] All military medical officers, both specialist and general, and any combination of military with non-military work.
[4] Public Health Clinic and any combination with university or hospital (combinations with solo or group have been counted above).
[5] Hospital or associated situation only. Includes Pathologists, Administrators, etc.
[6] University and university/hospital combination.

TABLE VII

NOVA SCOTIA SPECIALISTS BY FIELD OF PRACTICE, AND POPULATION RATIOS FOR CANADA AND NOVA SCOTIA[1]

Specialty	Full Time No.	Part Time No.	Total No.	Clin.-Equiv.	N.S. Pop. Ratio[4] By Equiv.	N.S. Pop. Ratio[4] By No.	Canada
Internal Med.[2]	34	48	82	67.9	11,619	9,622	10,463
Anaesthesia	15	22	37	33.6	23,481	21,323	19,704
Psychiatry	32	21	53	44.1	17,890	14,886	16,554
Paediatrics	13	16	29	24.0	32,873	27,206	25,674
Public Health	1	4	5	2.4	335,728	157,792	142,920
Radiology	23	26	49	42.9	18,369	16,101	22,831
General Surgery[3]	78	13	91	84.5	9,336	8,670	9,605
Neurosurgery	4	1	5	4.9	161,012	157,792	–
Orthopedics	9	1	10	9.9	79,693	78,896	47,853
Plastic Surgery	2	–	2	2.0	394,480	394,480	–
Urology	11	4	15	13.5	58,441	52,597	65,360
Ophthalmology	30	8	38	36.6	21,586	20,762)	
Otolaryngology	6	10	16	14.9	53,129	49,310)	29,407
Obst.-Gyn.	14	15	29	24.5	32,268	27,206	21,417
Pathology	24	13	37	33.1	23,836	21,323)	
Microbiology	–	5	5	2.6	303,446	157,792)	37,154
Unknown	1	–	1	–	–	–	–
TOTAL	297	210*	507	442.2*	1,785	1,559	1,746

*including 3 persons and 0.8 equivalents in Anat., Physiol. & Biochem.
[1] Canadian Medical Manpower statistics provided by J. D. Wallace, M.D., Secretary General, Can. Med. Assoc. Ottawa, Nov. 1972.
[2] Including Dermatology, Cardiology, Gastroenterology.
[3] Including Cardio/Thoracic Surgery.
[4] Based on 1971 census population for Nova Scotia – 788,960.

Dr. F. R. MacKinnon Talks To The Bulletin

Biography

F. R. MacKinnon, Ll.D., is a Pictou County native and a graduate of Harvard and the University of Chicago. Deputy Minister of Public Welfare for Nova Scotia since 1959, he has also served as Provincial Director of Child Welfare and as President of the Nova Scotia Association of Social Workers. He has lectured in the Maritime School of Social Work since 1941 to the present and is a member of the Accreditation Board, the Canadian Association for Education in the Social Services (Association of Universities and Colleges of Canada). He is also President of the Canadian Rehabilitation Council for the Disabled.

THE BULLETIN: What are your views on the complementary or co-related social service and medical professions and the services they provide?

DR. MacKINNON: Well, there are very obvious areas where the fields of public health and social welfare come together and overlap on occasion. The care of the aged is a good example. Traditionally and currently the public health authority is expected to provide leadership in areas of heavy nursing care – areas where the predominant in-puts are medical or psychiatric. There is a growing field of care – where the primary in-put is not so much medical as the provision of food, clothing, shelter and TLC – tender loving care – which perhaps more properly belongs in the social welfare field than in the medical field.

If we think of care as a continuum in which you have at one end of the scale the most active kind of hospital treatment moving along to the other end to uncomplicated personal care, then you will note that between these two extremes there is a whole range of care in which one must ask "What kind of in-puts are required to provide the kind of care required?" For example, if one looks at the care of the mentally retarded the medical in-puts are not very great and what is most often required is food, clothing, shelter, TLC and auxilary services, with perhaps no greater medical in-puts than a visit by the Doctor every week or so and the on-going supervision of a registered nurse.

THE BULLETIN: Is friction generated between the professionals involved?

DR. MacKINNON: The only likelihood of a problem is where the two areas of responsibility meet. For example, one of the obvious lacks in Nova Scotia, at the moment, is services for emotionally disturbed children. We have only one facility and that is limited in capacity. A number of community centered citizen committees have been pushing the government to take the lead in providing such services. This could be done by either Health or Welfare but by applying my test I think you will find that a really first

"The medical man may often exaggerate his conservatism while the social worker . . . may exaggerate his radicalism and activism."

class program for these children would require the primary in-puts to be medical and so I think these facilities should be the concern and responsibility of the Department of Public Health.

THE BULLETIN: Since rightly or wrongly in the past, on occasion, the medical profession generally has been criticized for not having a "social conscience", can I assume the doctors should start getting involved in these committees?

DR. MacKINNON: Certainly, but one reason for being careful in sorting out these responsibilities is that heavy medical care and active treatment is expensive, and if the circumstances do not indicate the necessity for it then one can get along on much less money by using other resources.

THE BULLETIN: Do you agree with the Hastings Report on the community health care concept?

DR. MacKINNON: I am very leery of Bill 65 in Quebec and in a paper I submitted to the Hastings Committee I spoke very strongly against any marriage of Health and Welfare as envisioned in Bill 65, although Bill 65 was not the side on which Dr. Hastings eventually came down. We have three

gigantic and powerful bureaucracies, Health, Education and Welfare. I'm increasingly wary of the theory that if you unify everything, tidy it all up, coordinate it and put it under one head that this will solve all the problems. The units of Health, Welfare and Education are too large and diversified to be put together into one structure.

THE BULLETIN: What are the best systems for achieving the necessary coordination of the social welfare and medical components?

DR. MacKINNON: Well, in Ontario they're attempting coordination at the political level with Health, Welfare, Education, Labour and Human Rights, each with its own minister and deputy minister, combined under a super ministry and a super deputy. In Quebec, Mr. Castonguay has married Health and Welfare. Bill 65 apparently dictates the terms of the union. Here in Nova Scotia the senior officials of the two Departments of Health and Welfare – including the deputy ministers – meet on the average of once a month and hopefully settle everything that relates to the interrelationships of our two departments. These meetings are formally structured with an agenda, minutes and a secretary.

THE BULLETIN: Are you saying that you have, in effect, a super ministry at the administrative rather than at the political level?

DR. MacKINNON: You could call it that and it is effective in solving our problems and avoids the creation of a super bureaucracy which would result from the amalgamation of these two large departments.

THE BULLETIN: Do you feel there is a need for personal involvement on the part of doctors in the human services by working more closely with social workers and others?

DR. MacKINNON: Yes. But medicine has a hundred years and more of solid technical knowledge of disease and treatment which although it is being refined and improved, still represents hard knowledge. Looking objectively and dispassionately at the broad social science field, apart from what's been done in the area of industrial psychology, the amount of hard knowledge is not great.

A lot of it is like cotton candy: too much of it is theory, philosophy and notions and much of it is unproven.

THE BULLETIN: Is this one of the reasons why people who are in your field are almost invariably faced with the tragedy of not having enough time or staff?

DR. MacKINNON: This has something to do with it. However, what I am really saying is that it is infinitely more difficult to find the answers in the social sciences than in medicine. In social work we are dealing with questions such as – "What is the nature of the human being? What kind of a creature is he and how does one change or modify his behaviour?" So little in known in this area. This lack of hard knowledge results in many social workers being on the defensive. The doctor feels secure. He has years of expertise and professional skill behind him. He has the highest status in the community, and quite properly so. The social worker needs the doctor especially in certain kinds of team approach to human problems. On occasion he is talked down to by the doctor. It's not hard to understand then why the social worker is on the defensive in many of these relationships.

THE BULLETIN: Is there any way of breaking that down?

DR. MacKINNON: I think we have broken it down in our relations with Public Health. The only way to break it down is to bring the two groups together. There is still sensitivity in respect to certain issues that touch on both fields and I can see our own people bristling over differences which, when viewed objectively, are really not that important. But conflicts do exist, growing out of the relationship and we would be unwise to ignore them.

THE BULLETIN: Would it be feasible to bring the agencies that exist in the community, the social workers, the medical practitioners, and perhaps the educators together from time to time to help develop better relations?

DR. MacKINNON: There's no question about the wisdom of that – that is the only answer.

THE BULLETIN: Some social workers seem to be involved in confrontation while some doctors talk about the welfare backlash.

DR. MacKINNON: We are dealing here with polarities. The medical man may often exaggerate his conservatism while the social worker, in order to embarrass and confront him on some basis of equality, may exaggerate his radicalism and activism. Neither group is necessarily as extreme as we think or seem to believe. Another point – although social workers appear to be working only with the most unfortunate people in our community, this is not always true. They work with people from all socio-economic levels of the community. It would seem that the services social workers provide to the middle and upper income groups are not talked about or appreciated to the same extent as those to persons in the lower income groups.

THE BULLETIN: I wonder if one of the problems is the fact that we tend to call Nova Scotia a "Have Not Province", and seem to have more people who need social assistance from a financial point of view, thus making welfare a dollar oriented thing where you keep people off the streets and keep a roof over their heads?

DR. MacKINNON: Yes, there's a very grudging public acceptance of the fact that the number of provincial and municipal dollars that we are spending on the unemployed is really relatively small – less perhaps than 5 per cent of the whole. The great bulk of our budget is being spent on children at one end of the spectrum and on old people at the other end, or on disabled people, and families where the breadwinner does not support the family due to death, disability or desertion.

THE BULLETIN: Do you think that one of the reasons for the wall that sometimes exists between medicine and social work is the attitude that the social worker seems to be

passing out the welfare cheque, when in fact he's much more involved with people than that?

DR. MacKINNON: You are posing a very difficult question. The social worker will try to look at the problem from the point of view of the individual and humanity. He will try to be realistic. Take as an example an unemployed man, age 35, of borderline employability. He appears to be a perfect physical specimen; he has a Grade 7 education; gets drunk every weekend and beats his wife. He shows up on the job late Monday morning when he fights with the boss; he finds it difficult to take direction; he does not get along with his peers and, generally, he is a poor worker – so he is the last man on the payroll and the first off. Then he has to go on assistance. He belongs to the 5 per cent; the small group that is so visible in the community and which everybody talks about. Because he is visible, he is the subject of criticism. The social worker sees this man in terms of the reality of things: he sees the five children who didn't ask to be brought into this world but who are here and have to be fed and who, twenty years from now, may repeat the cycle all over again. The community sees the problem in terms of punishing the miserable "welfare bum" who is getting what the media like to call – "The Welfare Rip-Off". It's very easy to talk about the "welfare rip-off" and "welfare bums", but this is the terrible dilemma the social worker is faced with in many of these cases. Some of welfare's most violent opponents would be the biggest softies if they had to really face the decision of what to do in such cases. It's not too difficult dealing with the single man – but when there's a family of children it's a very different matter.

THE BULLETIN: It seems that the provision of good medical care for, say, the wife of the man you just mentioned would be helped considerably if the knowledge of the social worker was made available to the doctor.

DR. MacKINNON: Certainly. There is a need for more communication. I do not know precisely where the fault lies. The doctor is busy, and the social worker has what he or she considers to be an overly heavy case load and so the two don't get together. The doctor voices denunciation against the bureaucratic forms he has to fill out for somebody applying for assistance but beyond that he has limited contact with the assistance side of welfare. Now that doctors and social workers are meeting together on Appeal Boards, there should be some improvement in this regard.

THE BULLETIN: Would it be possible for a great deal of the basic knowledge that the social worker, the doctor or the nurse need to be taken together in the education system to promote better understanding?

DR. MacKINNON: That might be a good idea. There's no doubt that a common element exists in the education of teachers, lawyers, social workers and doctors. Law and social work have much in common. Medical information is basic to the education of the social worker involved in casework.

THE BULLETIN: Where do you think the greatest need arises for cooperation between Health, Welfare and Education – the whole human service field?

DR. MacKINNON: Undoubtedly in the field of rehabilitation. I'm not talking of rehabilitation in the narrow sense of preparing people to return to the labour market. In any event, evidence would indicate that work opportunities in the traditional sense may become increasingly limited. Certainly, there will be less opportunity for the unskilled in the next 10-20 years – and this may be very upsetting to the person who worships at the shrine of traditional private enterprise. There is no solution to this dilemma except through a new approach to employment. It will have to be a modification of the LIP, Opportunities for Youth and the old W.P.A. concept, and it must come. We cannot allow people who have the capacity to be creative and to do things to simply vegetate. This will destroy us. Now I'm sure somebody will say that I'm merely giving voice to the Puritan Ethic – work for it's own sake – I'm not doing that. Some people may not like the word "work". Let's call it "involvement" instead of work. The human spirit will wither and die unless we are involved and committed in proportion to our capacity. I can't see a society or a world surviving in which we ignore that. That objective can only be achieved through massive government intervention on behalf of a very large group of people who will need to be involved. The traditional market economy will not solve the problem. We will have to be innovative in dealing with these people. I started talking about a new concept of rehabilitation and the phrase I would use is rehabilitation for well-being, whatever well-being means to you.

THE BULLETIN: Are you talking here about a preventive approach?

DR. MacKINNON: Yes. What I am saying is that "well-being" for a human being cannot be a life of aimless inactivity – a matter of receiving a dole from government. For the arthritic who is permanently confined to bed or the 18 year old who's had a motor cycle accident and has ended up as a quadraplegic, it should mean providing opportunities for each, taking their physical limitations into account.

THE BULLETIN: What about the young person who seems to be totally disenchanted with the kind of work ethic the older people in the community project on him?

DR. MacKINNON: I believe these young people are exhibiting an understandable frustration with life in general. Was it not Shakespeare who said – "Sweet are the uses of adversity"? This phenomenon has been upsetting for society but it should not be without its benefits and spin-off. It has forced many of us to take stock of our values and it is very doubtful if we would have done so otherwise. I'm not approving of "cop-outs"; but the example set by many of our young people has made us think and ask questions about the significance of many of our values and sacred cows in the Western World. We've all asked ourselves these questions; but our young people have had more courage and honesty than my generation.

THE BULLETIN: I gather from all you say that there is a very real challenge for people in Health, Welfare and Education.

DR. MacKINNON: Yes. And it would be very dangerous to leave the impression that what needs to be done should be done by government alone. There is a school of thought today which sees all progress in terms of monolithic and managerially efficient structures in which there is very little room for diversity and difference. With some there is complete intolerance of anything that smacks of letting people do their own thing within the system. I think it is terribly important that the systems we develop in the next decade or two are not permitted to get off on this tangent of bigness, uniformity, coordination and sameness to the point where a lot of good things do not happen because individuals and individual communities are stifled. We are top heavy with health and welfare agencies doing their own thing and perhaps we could do with fewer of these and greater efforts at coordination. However, it would be to the detriment of our community and our civilization if, in our zest for uniformity and efficiency, we destroy or impair the opportunity for individual effort in community betterment. Representatives from some Iron Curtain countries have visited North America and expressed interest in our system of citizen involvement and voluntary agencies, which is rather unique. They have enquired how it is done here and they have tried to incorporate it in their monolithic system of government.

THE BULLETIN: When you mention the citizen level, do you mean the professional level?

DR. MacKINNON: Yes. I include both. □

The Prescription

YOUR COMMUNICATION, DOCTOR

J. F. Cox, M.D.,
Halifax, N.S.

The importance of proper prescription writing is, to say the least, something that falls into the same category in Medical Schools as the Physiology of Sex and Family Planning.

Prescriptions are a communication, a directive, instructing the pharmacist to dispense a medication for your patient. The instructions should state clearly the type of medication expressed by the generic name, trade name or if a possibility of name confusion or compulsory drug substitution exists, include the manufacturers name.

Having instructed the pharmacist what to dispense, including the strength of the drug, it is of no less importance that the patient understand how and when to take it. The patient should on most occasions be instructed regarding what medications he or she is receiving before leaving the office and this to be clearly reinforced by the typewritten instructions on the prescription label. Medications such as suppositories and antihistiminic drops pose a special problem to some patients. Suppositories with the foil or plastic protective coating left on are very poorly absorbed. Simple things should not be taken too much for granted.

As well and especially with the antibiotics, the patient should know which one they are taking and be reminded of the number of days it is to be taken. Many patients will discontinue medications on their own volition when the symptoms subside only to experience an exacerbation days later.

It is also important that the physician convey to the pharmacist how long you intend the patient to remain on the medication. This should be stated in the number of repeats the patient may have, i.e.: Repeat q 30 days for 12 mos. Many drugs are potentially lethal and for the suicidal as convenient as a firearm and less messy. It is important for these patients as well as for the scatter-brained that the physician thwart their efforts to obtain an overdose by "cost saving" large prescriptions and to prevent stock piling by issuing minimal quantities with specific renewal periods.

The labelling of prescriptions with the trade-name of the drug is vital. The frustration of trying to figure out what Aunt Lou's little red pills are after the baby swallowed them is incomprehensible. Most patients should know what drugs they are taking and for what reason they are on them. It is interesting that fifteen months have passed since the Medical Society of Nova Scotia approved the resolution that all prescriptions should be labelled with the name and strength of the drug dispensed unless otherwise indicated.

Three out of five prescriptions are still dispensed unlabelled.

A final point worth mentioning is the practise in some offices of the receptionist renewing prescriptions for patients. Fortunately, many pharmacists will not accept this form of renewal and are within their legal right not to do so. They phone as a service to your patient, not as harassment. It is the physician's responsibility and not the receptionist's to renew prescriptions. □

Nova Scotia Interne Training

RINGING THE CHANGES

M. R. Macdonald*, M.D.

Halifax, N.S.

Until very recently, approval of interne training was the prerogative of The Canadian Medical Association and was acquired by applicant hospitals on the satisfactory completion of a questionnaire. But time marches on, and CMA itself has concluded that this "paper assessment" is not enough and that the provincial licensing bodies should conduct on-the-spot team assessments of CMA approved programs within their jurisdiction.

Currently, there are about 80 hospitals in Canada with CMA approval for interne training, and precedent exists for such on-the-spot assessments within the CMA program itself; notably on-site surveys performed in Alberta and Ontario hospitals which have proved valuable.

Just over a year ago, representatives of all provincial licensing bodies endorsed the CMA on-site assessment proposal and agreed to assume this responsibility, using the same basic evaluation criteria.

The first on-site assessment in Nova Scotia will be carried out by the Provincial Medical Board in April of this year. As the program develops, it will have its roots in certain prescribed educational experiences in medical accreditation which, Provincial Medical Board Registrar Dr. M. R. Macdonald has stressed, "will upgrade the teaching and also the service component of the interneship program".

The Board has also recommended a process whereby the medical student will apply to the University instead of the Hospital for an interne position. In effect the hospital based interneship program is replaced by a university integrated program under the direction of the Faculty of Medicine of Dalhousie University. Although this move may now see internes undergoing training in more than one hospital, institution or community setting, his or her training will always be a part of a cohesive university integrated program.

Now a matter of fact, the Board's concept of such a program is as follows:

1. The university affiliated hospitals must be fully accredited by the Canadian Council on Hospital Accrediation (C.C.H.A.).
2. There shall be a written agreement between the Faculty of Medicine and the university affiliated hospitals which allows for joint appointees on the hospital teaching staff.
3. The interneship must have C.M.A. approval.
4. The affiliated hospital agrees to provide the necessary resources to the Faculty of Medicine to allow for an adequate interne training programme.

   In hospitals which are included in the university integrated programmes for undergraduate teaching, clinical clerkships and postgraduate teaching, the hospital will agree to provide the necessary resources for these programmes.
5. The Faculty of Medicine of Dalhousie University undertakes to ensure that this training is an educational as well as a "service" experience.
6. "On the site" inspections of hospitals associated in the university integrated programme are mandatory, by committees appointed by the Provincial Medical Board. This applies to all hospitals involved in the interne training, even if a hospital is providing only a part of a total training experience, e.g. a four weeks rotation in obstetrics or gynaecology, for one interne.
7. A certificate of satisfactory interneship shall be obtained by the interne from the university appointed director of the interne training programme.
8. Interneship is a continuation of a medical student's education and should basically be a more practical type of learning experience. The university integrated programme and the inspections should allow for the different types of interneships which a student may desire to take, which at present are usually classified as follows:

   (a) *Rotating Interneships* – If a student has not taken a clinical clerkship, which complies with the requirements of the Federation of Provincial Licensing Authorities, he must take a rotating interneship. This rotating interneship is of twelve months duration and must include a minimum rotation of six weeks in medicine, paediatrics, surgery, psychiatry, obstetrics and gynaecology; the remaining time may be taken in any service.

   (b) *Straight Interneships* – If a student has completed an approved undergraduate clinical clerkship, he may take a straight interneship in any medical discipline, for one year, preparatory to entering upon graduate training in a specialty.

   For the interne who desires the straight interneship to be credited as one of the required years of resident training, the clinical

*Registrar, The Provincial Medical Board of Nova Scotia.

clerkship which he has completed must be acceptable to the credentials committee of the Royal College of Physicians and Surgeons of Canada.

(c) *Clinical Clerkships* – The Federation of Provincial Licensing Authorities has approved the following as minimum requirements for the undergraduate clinical clerkships and the Medical Board of Nova Scotia concurs in these minimum requirements.

The clinical clerkship shall involve supervised responsibility for the care of patients and be of at least forty weeks duration, exclusive of holiday time, and including those clerkships regularly scheduled for all students and those chosen as electives. It shall be in the second half of the total undergraduate medical curriculum. Clerkship experience shall include at least: Medicine – eight weeks: Surgery – eight weeks: Obstetrics – four weeks: Paediatrics – four weeks: Psychiatry – four weeks: Non-clinical periods, whether prescribed or elected, shall not be considered as part of the forty weeks of clinical experience.

(d) *Family Medicine Interneships* – First year Family Medicine programmes which are approved by the Faculty of Medicine of Dalhousie University and by the College of Family Physicians of Canada will be accepted as satisfactory interneships for licensure, provided that the curriculum in that year is equivalent to a rotation.

This first year Family Medicine interneship is also the first year of Family Residency training, leading to certification by the College of Family Physicians of Canada.

In summary, The Provincial Medical Board of Nova Scotia has recommended that any hospital in Nova Scotia desiring approval of interne training programmes must apply for approval to the Medical Faculty of Dalhousie University. Dalhousie Medical Faculty must accept responsibility for the organization and operation of all interneships approved by it in Nova Scotia, within the guidelines as laid down by the Federation.

Committees appointed by The Provincial Medical Board of Nova Scotia will carry out "on-the-spot" inspections of all interne training programmes in Nova Scotia every five years. One-fifth of the interneships should have their inspections yearly, thus enabling an equal number to be done each year. □

Nova Scotia Health Council Report

In this issue of the Bulletin there is a centre insert on the subject of the recently released Health Council Report. The article is an attempt by the Officers to provide Society members with a concise rundown on the essence and significant features of the Report. As well, an attempt is made to clarify Society policy relative to certain of the recommendations.

All members of the Executive Committee, Branch Presidents, Branch Secretaries, Section Chairmen, most Committee Chairmen and Dr. R. N. Anderson's Levels of Care Project Team have been provided with copies of the Report at Society expense. These are *not* intended as personal copies. It is hoped that Branch and Section Executive Committees will organize themselves to undertake comprehensive review of this Report. All Society members should be given the opportunity to participate in review of this Report and to express their views.

In the Council Report there are numerous references to Medical Society participation in future projects relating to development of our medical-hospital programs. Membership response to Society requests for service on volunteer committees working on various studies etc., will be essential. I hope you will co-operate.

Membership reaction to the Special Report on the Nova Scotia Health Council Report which appeared in the March 3, 1973 issue of the C.M.A. Journal compels me to confirm in the strongest possible terms that it does NOT represent Society policy. The Special Report was written for C.M.A. by Mr. R. H. Knox, Executive Director of the Health Council. □

J.A.M.

Perspectives in Continuing Medical Education for Maritime Physicians

Marvin R. Clark*, M.D.

Halifax, N.S.

This is the first in a series of articles which will appear in the *Nova Scotia Medical Bulletin* pertaining to the continuing medical education of Maritime physicians. These articles will attempt to identify and interpret the perspectives of the community practitioners as revealed by personal contacts and through the Maritime Physicians Survey.

This first article will serve more as a background to the current state of affairs.

History

Dalhousie has been a leader in the North American scene since its first Dalhousie Refresher Course, arranged in 1922. The unique and rapid development of the Division has evolved from a Faculty of Medicine Committee appointed in 1949 to look into the matters of postgraduate and continuing medical education, to the establishment of a Postgraduate Division in 1957, and finally to the fully operational independently staffed Division of Continuing Medical Education as we know it today.

Even without mandatory demands toward relicensure, the total number of physicians involved in last year's programmes are estimated below:

41	– Clinical traineeships
575	– 16 short course offerings
1243	– 240 community hospital programme offerings
1859	

At the present rate of increase in participation, we anticipate enrollment will reach a total of approximately 2500 by 1975.

Objectives

1. To encourage in medical students and graduate physicians the development of life-long learning habits, and a sense of personal responsibility for continuous self-education.
2. To aid the physician to increase his knowledge through the provision of lectures, seminars, study carrels, private tutorials and small group discussions.
3. To assist the physician to improve his skills through practical teaching demonstrations and participation, and by means of audio-visual programmes.
4. To encourage development of attitudes in the physician which will assure thorough and adequate patient care, and a consistent desire to maintain his knowledge and skills at a high level of competence.

Staff

• Dalhousie University's Division of Continuing Medical Education is actively preparing itself for its increased role in the provision of educational answers to needs identified in the area of quality health care delivery. The present staff consists of:

FULL-TIME STAFF	PART-TIME STAFF
– 4 secretaries	– one Master of Arts (Education)
– Health Sciences Librarian	– one Medical Records Librarian
– Medical Educator – M.D., M.A. (Ed.Psych.)	

Extensive interviews are presently being conducted to locate another medical doctor (as assistant director) and some part-time educational researchers.

Community Based Programmes

Plans include a much more specific identification of individual and group educational objectives based on real needs as determined by innovative methods of evaluation of care in the practice setting. A major emphasis is being directed to continuing medical education provided by resource persons in regional or local areas.

Special consideration is being given to directing community based programmes to special interest and specialty groups as well as combined gatherings of interested medical staffs. It is our full intention to incorporate more topics in the future, which have an emphasis on the health care delivery systems as well as the preventive and rehabilitative aspects of medical care.

We also hope to offer continued support to the stated objectives of the medical school; i.e., creating a life-long self-learner by moving as rapidly as possible in the direction of supporting educational programmes in the physician's daily working environment.

Not only will this be more cost and time effective, but considerably more in keeping with proven educational principles of efficiency and effectiveness in adult learning.

During the past few years Dalhousie has been pleased to find itself supplementing ongoing self-motivated community based programmes, rather than the sole provider of intermittent educational offerings.

*Assistant Dean and Director, Division of Continuing Medical Education, Dalhousie University.

Another new development has been a marked increase in the level of sophistication demanded by many of the larger communities for specific, in depth, day-long programmes (Clinical Days) based in the community.

University Based Programmes of Continuing Medical Education

These consist of five major types which are briefly described below.

1. *Clinical Traineeships* – These are individualized programmes based on objectives relevant to the individual practitioner's daily encounters and situational limitations. These consist of a 1:1 tutorial, balanced clinical experience and guided independent study. These educational offerings are proving increasingly popular and have a high rate of resubscription.

2. *Short Courses* (Refresher Courses) – This group of programmes, usually 12-14 annually, is rotated on popular demand through specific topic areas of general interest. The trend in recent years has been to provide an in-depth review and future perspectives into the field under consideration, rather than the once popular, quick, and superficial overview.

3. *Regional Library and Information Transfer Service* – A senior regional health sciences librarian is devoting full time to designing an efficient and effective library service for the Maritime region. It is proposed that the service will be so structured as to be an integral part of the ongoing patient management as well as a reference service. Hopefully governmental and professional support for the concept will be forthcoming when the grant is prepared in early 1973.

4. *Faculty Programmes of C.M.E.* – The Division of Continuing Medical Education is offering its educational consultation support service to the Faculty of Medicine for ongoing Faculty Programmes and C.M.E. The most well-developed of these to date is a combined departmental and general Faculty based "Friday at Four" programme series.

5. *Consultation Services* – Increasing use is being made of the expertise and support services of the Division of Continuing Medical Education by medical organizations. These consist of such groups as the Royal College of Physicians & Surgeons of Canada, the American College of Physicians, the College of Family Physicians of Canada, the Atlantic Provinces Radiological Society, the Atlantic Provinces Orthopaedic Society, etc. This mechanism avoids unnecessary duplication and conflicts as well as permitting a general improvement in the quality of educational programmes offered.

Identifying Needs

The steady evolution of the medical profession toward becoming more active in the role of maintaining quality patient care has been very exciting. Support in principle of the Medical Society and provincial licensing authorities is encouraging.

The Division has initiated a long-range programme strategy of Patient Care Appraisal through increased staffing (eg, Medical Records Librarian), medical audit workshops and communication directed to all levels regarding the necessity of educational, non-punitive approaches to quality control. Such methods as medical audit (PAS/MAP, HMRI), peer review, office audit and critical incidence studies are appearing over future horizons. This type of innovation, linked with better systems of records, practice and personal profiles from computerized systems offer great educational potential in the near future.

A unique and comprehensive study has been conducted in the Maritime area (Maritimes Physicians Survey) in matters related to physician perspectives of past programmes, physicians' suggestions for future programmes, the relationship of office organizational aspects to C.M.E., and physicians' viewpoints of the role of other health professionals in health care delivery. Funding and manpower shortages have stopped analysis of the data at the present time.

Instructional Methods

A great many variations and combinations of methods are used in the programmes offered by the Division. Methods are matched to the entry status of the participant, identified educational needs, abilities of the teacher, and objectives of the programme. There appears to be a general trend toward small group teaching with very specific and limited goals. Self-assessment and self-study opportunities are rapidly gaining widespread acceptance.

Teacher Training Programmes

This area has been separated from the other programme areas to emphasize its unique importance at both the university and community levels. We must continue to take advantage of improving attitudes of physicians to accept such educational programmes.

Evaluation

The single, most crucial area in medical education at present is the area of educational evaluation in relation to established criteria of health care. Unless we can immediately deploy significant resources (financial and personnel) to this area, all else may prove fruitless. It is our belief that no less than 30% of our entire Divisional effort for the immediate future should be expended on evaluation.

Educational evaluation must be directed toward measuring changes in physicians' practice behaviour in relation to quality health care. Such efforts must combine several strategies: determining educational needs; objectives at the personal and group levels; methods of meeting these needs (eg, lectures, small groups, individual study); amount of

time required in C.M.E.; location of such programmes; etc. Needless to say, answers to these questions should precede legislative restrictions on the individual's methods of maintaining personal competence in his field. To my knowledge, little, if any money, personnel or efforts are being expended in this area. We look hopefully for both internal and external support in this area of evaluation. We have greatly increased our internal efforts at cost effectiveness studies in relation to present programmes.

Future Horizons

As we look forward in the immediate future to a greatly expanded role for continuing medical education for physicians, it is not too difficult to conceive of this horizon expanding to include all other health professionals. Unless we can take advantage of the combined experience of educators, health professionals, hospitals, community colleges and governmental representatives, etc., unnecessary delays, duplications, and expenditures are inevitable.

We sincerely appeal to individual physicians, medical societies, hospitals, voluntary health agencies, private organizations and governmental bodies to assist us with continued and increased funding for these important tasks. We in the profession of medicine must assume full responsibility for guaranteeing quality health care from competent practitioners to the public of the Maritimes. ☐

Physician Self-Assessment

Lea C. Steeves, M.D.

Halifax, N.S.

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

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

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

263. A Public Health Nurse calls at the home of a patient who has just been admitted to the hospital because of pulmonary tuberculosis. The nurse sees the patient's 17-year-old daughter and places a tuberculin skin test on the girl's right forearm.

The use of isoniazid for one year should be seriously considered with which of the following test results?

(A) an area of erythema 12 mm in diameter at 24 hours
(B) an area of erythema greater than 10 mm at 48 hours with an area of induration of 3 mm diameter
(C) erythema with an area of induration of 9 mm in diameter at 48 hours
(D) an area of induration of 3 mm and an area of erythema 6 mm at 48 hours
(E) none of the above

264. During the last three months, a 55-year-old man has lost 18 lb in weight and has been coughing blood-streaked sputum. The patient had been successfully treated for pulmonary tuberculosis two years ago. Repeated cultures had been negative prior to discharge from the hospital. However, he has had no follow-up care since that time.

Examination of the chest shows no change, but the patient now has clubbed fingers. Roentgenogram of the chest is also unchanged showing a very small area of fibrotic infiltrate in the left upper lobe. The left diaphragm is distinctly higher than on films taken two years ago.

At the present time, which of the following is the most likely diagnosis?

(A) recurrent active pulmonary tuberculosis
(B) progressive pulmonary fibrosis
(C) carcinoma of the lung
(D) progressive obstructive lung disease
(E) bronchiectasis ☐

(Please turn to page 75 for answers)

Chiropractic: Facing The Question

The following is an address delivered to the Nova Scotia Chiropractic Association by Medical Society President J. A. Myrden on March 10, 1973.

Mr. Chairman, Gentlemen:

While I am grateful for the opportunity you have afforded me to speak frankly and directly to you as a practising physician and as president of The Medical Society of Nova Scotia, I can't help but feel that we have a situation here something like Daniel's entry into the lions' den.

And to be truthful, I'm not sure whether I qualify as a Daniel or as a lion. Perhaps you will be able to make that kind of definitive judgement after hearing me out.

It's not too long ago that chiropractic and The Medical Society of Nova Scotia met head-on in the chambers of government. All of you are aware of the determined opposition the medical profession mounted against the legalization of chiropractic philosophy and its application in this province, notwithstanding legislation in other jurisdictions. And, to be fair, I think you will agree that the Medical Society had pretty good grounds for voicing that opposition.

But I would like to make absolutely sure here today that you all understand that the medical profession's opposition to chiropractic in Nova Scotia was and is based solely on the grounds of firsthand clinical experience, other reliable medical sources, and our own assessment of chiropractic's published Canadian training curriculum and not – may I stress, *not* – on any personal grounds involving any single spokesman for chiropractic in Nova Scotia or any Nova Scotia chiropractor.

You may ask: Now why would he say that? Of course we understand that. It was a strenuous but gentlemanly confrontation.

Well, I think you'll understand my wish to stress that point a little later on in my talk.

The fact right now is that chiropractic is a legally established entity under Nova Scotia law. The only discernible impact the medical profession's opposing counsel to government had, as far as I can see, was certain amendments and deletions in the act as originally presented. You may not like what happened to the act, but the fact is you have one . . . and Nova Scotia has chiropractic under law.

The Medical Society, however, still opposes chiropractic and is very concerned indeed about the problems which may confront us both in the future – problems which relate directly to the health of individual Nova Scotians and not simply to disagreements between doctors and chiropractors.

The Medical Society has already taken a first step in trying to resolve what might have become a serious problem by declining an invitation to appoint a member to the Chiropractic Board. *This is not because we wanted to assume a dog in the manger attitude just because chiropractic had been legalized.*

Quite frankly, we carefully assessed the contribution a physician holding a minority position on such a board might be able to make, and concluded that this contribution would be far outweighed by what we considered to be the danger of having the public interpret doctor-participation to be an endorsement of chiropractic as a facet of medical science.

We were and still are very, very concerned that lay persons may seek and rely on the application of chiropractic to the exclusion of any other form of assistance and, by so doing, allow an incipient health problem to attain crisis proportions. Apparent physician endorsement of chiropractic through representation on the board would, we were convinced, do more to encourage this sort of problem than any regulatory counsel the profession might proffer would do to prevent or alleviate it.

However, as I have already stated, chiropractic is a legal entity in Nova Scotia and, as long as chiropractors are dealing directly with people who have health problems, I and the members of the Medical Society sincerely hope that they recognize their limitations – particularly in the field of diagnosis.

Gentlemen, the Chiropractic Act may be a very welcome act in terms of your aims for your vocation but it has thrust a great deal of responsibility upon you – the kind of responsibility which I hope both your association and the Board of Chiropractic will underline on a day-to-day basis in much the same way the Medical Society and the Provincial Medical Board treat the individual practice of medicine.

I don't wish to sound patronizing but I must stress that the accurate diagnosis of disease can be and often is an extremely complicated business requiring the expertise of several or many highly trained medical and technical specialists. The treatment of many diseases falls into the same category.

If, in the application of chiropractic to any person seeking your assistance, you have cause for the slightest doubt as to your ability to diagnose a problem, I strongly recommend that you urge that person to seek a qualified medical opinion from a physician or physicians licensed to practice medicine in this province.

I am most decidedly not suggesting that chiropractors and physicians establish a system of referrals – although personal preference on your part might lead to a trend in

that direction — because to suggest this sort of procedure could also lead to potentially dangerous inferences on the part of lay persons seeking health assistance.

But I do urge you to consider the rights and the needs of the person who does seek your advice and to make the most scrupulous assessment of your own abilities — again, particularly in the field of diagnosis.

In saying this, I should point out that this is the same approach the Medical Society takes towards its own members. As a society, we are insistent not only on continuing self-evaluation but also on the rapidly developing program of peer review which will allow an objective evaluation of a doctor's skill and competence and which will either endorse his competence or lead to steps which will guarantee it is upgraded in those areas where improvement is indicated.

I would also like to stress that even though the Medical Society has no regulatory powers under the Medical Act, it has been a constant goad in the side of the Provincial Medical Board to ensure that investigatory and disciplinary action is taken where it is called for.

As a physician and as president of the Medical Society I hope that chiropractic will follow the same ethic of a single overriding objective — the ultimate well-being of those seeking help.

Finally, I cannot tell you that the medical profession in Nova Scotia will ever endorse chiropractic. In fact, I can foresee instances in the future where physicians and chiropractors will find themselves in singular and group opposition again. I am sure that long after I have retired as president, the Society will be keeping a very concerned eye on chiropractic and its implications for the public health.

You see, we regard the problem of medicine versus chiropractic as more than a reconciliation of differences. You have theories about the human organism which time and time again massive public and private investments in scientific research and the cumulative expertise of clinical experience have brought into grave question. Certainly, the American experience has not helped your cause, although I am sure many Canadian physicians have found some solace in the fact that Canadian chiropractors have tended to disown the antics that have taken place south of the border.

Heaven knows, the Medical Society is the last group on earth which would wish to see any person's job or vocation legislated out of existence, or to discourage the legitimate aspirations of any individual to serve mankind, but we do have an overriding commitment to our patients which must be served.

As an individual I can wish you well. As a physician, I ask only that your commitment be to the true needs of the person who seeks your assistance. As president of the Medical Society of Nova Scotia I can promise continued opposition to the health ethic you espouse but I will qualify that by assuring you that all Nova Scotia physicians recognize your legally established rights and ask only that you respect the rights of the public to the fullest, most comprehensive health care possible.

Thank you for allowing me to speak frankly to you today and for having the patience and courtesy to listen to comments which may have caused you some distress.

Thank you. □

Informing the Public

Announcement of a Chiropractor in Minnesota

"Abrams knew that the body — that all things, ert and inert — are composed of electrons. Radio is the activating of a flow of electrons that radiate in all directions, carrying along with it the sound waves which are heard in the receiving sets in your home or elsewhere. Goiter is quite prevalent, especially since the Flu. The reason is that most goiters are caused by streptococcic which the Flu germ brought about."

*Reprinted from the Nova Scotia Medical Bulletin. Jan. 1, 1925.

At the last Annual Session of the American Medical Association, seven cases of dislocation of the ceryical spine, a forward dislocation of the Atlas on the Axis, were reported. These were all due to the ignorant and rough manipulations of Chiropractors.

*Reprinted from the Nova Scotia Medical Bulletin, April 1926.

The Hielan'man's Prayer

Oh Lord — Lord o' the glens an' the bens, an' the hills, an' the stills an' the gills, an' the hauf-mutchkins — hear oor prayers. Pless a' the pig Floras an' the wee Floras, an' the pig Archies an' the wee Archies, an' the Ronals an' Tonals, an' Tugals, an' the rest of us moreover. Pless a' oor wee coos an' wee soos, an' oor prave polismans specially, an sen't them plessins too. An' Lord, don't foregt to sen' us some whusky, an' after that some more whusky; an' sen us hills o' joy, an' mountains o' love, an' rivers o' prose, an' oceans o' whusky more specially. An' Lord, pless a' oor ponnie pagpipes, an' oor ponnie pagpiers too moreover; an' sen' them' win Lord, gales o' win' to fill their pipes an' soont them in Thy praises. Lord pless oor pig coos an' oor wee coos, an' oor pig soos an' oor wee soos, an' oor polismans pertik'ler. Mak' them prave, Lord an' always ready wi' their patons to knock tamination oot o' the Lowlanters.

An' ton't forget, pless us a' to-day, an' to-morrow, an' the mornin' pebore, an' Lord, do not forget the whusky, an the glory be Thine for evermore.

Amens

*Reprinted from the Nova Scotia Medical Bulletin, Dec. 1927.

First Annual H.B. Atlee Lecture

OPPOSITION TO BIRTH CONTROL

Lise Fortier*, M.D.
Montreal, Quebec.

Physicians can be proud of their achievements in the field of medical techniques but in that of philosophy they have not evolved so rapidly and for many years, they fought contraception with ferocity. Up to the end of the 19th century in England, although high maternal and infant morbidity and mortality were worrying the medical profession and although this morbidity and mortality was often related to a non-controlled fertility, the medical profession during more than forty years tried to ignore the causes of the problem. Around 1860, it was no longer possible to ignore the situation and violent opposition developed. Lord Amberley, the father of Bertrand Russell, was accused of having scandalously insulted the medical profession when he suggested that it should interest itself in contraception. In 1887, a physician named Albutt was expelled from the medical society because he had published a textbook in which there was a chapter on contraception. During many years, the word contraception was never printed without a series of adjectives such as "egoist", "immoral", "lustful"; it was claimed that contraception caused cancer, sterility, nymphomania, suicide and amnesia. On the other hand, it was easy to deduct, from the size of their families, that physicians were the first to practice birth control. As recently as 1905, the British Medical Association condemned the use of contraceptives. It was only after the first world war that, slowly and reluctantly, physicians began to change their views. It was the availibility of oral contraceptives for which medical prescription was needed and also the orientation of medicine towards preventing rather than curing which really forced physicians to change their position.

H. B. ATLEE, M.D.

In 1972, on the occasion of the 50th anniversary of the establishment of the Grace Maternity Hospital, the Department of Obstetrics and Gynecology of the Dalhousie Medical School instituted an annual lectureship in Obstetrics and Gynecology.

This tribute to the service provided over the years by the Grace Hospital is to be known as the H. B. Atlee Lectureship, to honor both the hospital and its first "Obstetrician in Chief". Doctor Atlee, well known to all Nova Scotia physicians, enjoys his retirement and maintains a lively interest in the affairs of the profession and the hospitals. Himself an outspoken and vigorous teacher, the lecturers who will give the annual Atlee Lecture will be persons of high scholarship who will discuss important and current topics in the field of Obstetrics and Gynecology.

The first lecture was delivered by Doctor Lise Fortier, May 4, 1972, during the Jubilee Celebrations of the Grace Maternity Hospital. She is Professor of Gynecology at the University of Montreal, and a great medical pioneer particularly in the field of planned parenthood service and education. A striking and outspoken person, Doctor Fortier's lecture is presented by the Bulletin both for its own merit and to honor Doctor Atlee himself. □

Religious and sexual taboo explained those attitudes and they have not disappeared with the Victorian Age. As an example of this, everybody still discusses family planning which implies that only persons who are legally or religiously made up as a family can use contraception. In reality, under an euphemistic term such as "family planning", we are discussing "birth planning" and in a broader sense still, contraception. All family planning implies contraception, but not all contraception is necessarily family planning. Thus, prostitutes need contraception but it would be hypocrisy to call this family planning. This also applies to teenagers experimenting with sexuality or to the couple who, without any desire to procreate, lives together in common law.

This reluctance to words expresses a reluctance to the idea of contraception, reluctance that physicians have shown as much as other people. In fact, this reluctance turns out to be a frank opposition when sterilization and abortion are concerned. One of the main objections of hospitals to liberalized abortion and sterilization is that they will do only those two kinds of operations, and consequently they won't be able to train skilled obstetricians and gynecologists. But about ten years ago, when

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reliable means of contraception were still not widely available, nobody was complaining because residents in obstetrics and gynecology spend at least a third of their time doing D. & C.'s for incomplete abortions (most often criminal abortions) or watching over normal deliveries. As long as it was nature (as they then believed) and not women who were forcing them to do it, physicians had no objection to being only technicians.

There is still today a lot of opposition to contraception which, in my opinion, is not church-centered but male-centered.

After all, medicine is a man's world, until recently forbidden to females, and physicians, by becoming physicians, did not rid themselves of their prejudices as males and of their everlasting desire to dominate females. Through law, religion, economy, tradition, all human rights are now recognized as fundamental; the right to vote, the right to own property, the right to be educated, the right to self determination were denied to women. When this attitude became very difficult to justify, we unwillingly granted those rights in theory, although in reality it still seems that we are living with double-standards. Psychiatry also, has accentuated those double-standards. Freud has described the envy of the penis as an essential component of the feminine psychology. To be sure in the Victorian Age which was his, the golden age of the double-standard, when everything was permitted to man and everything forbidden to women, a sensible woman could not but realize, what privileges the ownership of a penis could bring and, by deduction, desire one. Freud and many of his followers came to the point where they considered woman as an incomplete being, one without a penis. Surprisingly, they never saw men as being without a uterus! The functioning of such an incomplete being could not possibly be normal so it had to be modified. From this came what I call the "delirium of the vaginal orgasm". Contrary to most elementary common sense, (that shows the clitoris is the physiologic counterpart of the penis and, as such, the seat of the orgasm), man wanting to believe that the mere fact of introducing his penis in the vagina of the woman, should give her great ecstasies, has postulated that in women, orgasm must be transferred from the clitoris to the vagina. Nobody would have ever thought of asking man to transfer the orgasm from the penis to the scrotum. But for women to do such an impossible task (if one thinks of the natural insensivity of the vagina, in which a foreign body can be introduced and as soon forgotten), was considered quite normal. In the same order of thinking, one can not escape comparing the carelessness with which thousands of ovaries were removed for the most tenuous reasons, while everybody was treating testes with the outmost respect, not permitting them to be suppressed unless under a threat of death. A psychiatrist once asked me to sterilize a young woman who's suicidal tendencies were apparent, in his opinion, only during her premenstrual period. The thought wouldn't have crossed his mind to castrate a man because the same tendecies had shown themselves after ejaculation.

With this as a background it seems interesting to look at one rule of accreditation for hospitals, whereby, one must consult if there is to be an operation resulting in the sterilization of a woman when this woman is still in the reproductive age, whatever the reason for this intervention may be. Was this brought about by the abuse of unscrupulous physicians who had been doing hysterectomies, as a quick way to fortune? If so, why is consultation still asked for women who have cancer and why is it not required after women have passed the age of reproduction? Or why it it not required for tonsilectomy or appendectomy, to take as an example two kinds of operations which were done without rhyme or reason? For those two operations, it seems that a tissue committee is sufficient. There is no need for consultation prior to a craniotomy or a gastrectomy. Does this mean that the reproductive function of a woman is more important in the eyes of physicians than her life? A woman shouldn't be deprived of this function unless for very serious reasons; she must not excape pregnancy. That certain women have begged for hysterectomy, to put an end to their undesired pregnancies, does not justify this rule. It only underlines the fact that physicians were not fulfilling their obligations to offer alternatives, that they were not fulfilling their obligations to protect the mental and physical health of women. That to the control of the tissue committee, one must add a mandatory consultation with another gynecologist, only falsifies the object of the consultation; now-a-days, this consultation is most often a matter of formality, whether it comes from somebody in whom we have total confidence or because it would bother us to object to a decision unless this decision is very evidently a mistake. Consultation shouldn't be a way to control the doings of a physician, but rather a way to enlighten him and to help him to make a decision. Consultation is also mandatory in case of cesarean section. I have known a time when everything was tried, short of killing the mother, rather than section her, so that she would come to the cesarean section almost moribund. In view of this, the consultation for section seems to me a bad joke. One wonders from where all these precautions emerged when one knows that the great causes of maternal mortality hemorrhages, toxemia, infection have in great part been controlled by cesarean section, now so benign, that it can be compared to a normal delivery. Is it, that one looks with suspicion on everything that permits a woman to free herself from the danger and the pain of having a child? Before hastening to refute this seemingly ridiculous hypothesis, think of the great scandal brought about by the use of anesthesia in obstetrics, because woman was meant to give birth in pain.

Other behaviour which reflects the same philosophy is that by which physicians have tried to convince women that pregnancy is a normal situation, desirable physiologically and socially, and that not to become pregnant is a failure. They kept silent about the real dangers of pregnancy when the mortality rate was around 45 per 1,000 and did not drop until, from the knowledge of the

important changes produced in the organism by pregnancy, physicians treated it as a disease demanding intensive care. Whenever I point out to other physicians that the maternal mortality dropped only when they started treating pregnancy as a disease, even the most broadminded jump and tell me that, after all, pregnancy is a normal function of the organism. Certainly it is a function; and if normal means that it is shared by most, certainly it is a normal function. But to say that it is normal, in the sense that like other functions, it helps to maintain the health of the organism, I disagree. I do not say that pregnancy is a disease because I am not sure what is a disease or, how to define it, if not by defining health. Those two terms have been the subject of much controversy by minds better equipped than mine, to deal with philosophy and semantics. But whatever definition you turn to, it boils down to a departure from the state of health or an abnormal state of the body as a whole. It can be said to manifest itself subjectively by abnormal sensation essentially unpleasant, worrying or painful. In human medicine it is a group of abnormal phenomenona, physical or psychological, having one or many causes, endogenous or exogenous, generally but not necessarily known, and which can be accompanied by pathologic manifestations – functional, biochemical or morphological. If disease is an alteration of health, what is health? The most accepted, but still very controversal definition is the one of the World Health Organization, which defines health, not only as an absence of disease, of physical disability, but as a mental, physical and social feeling of wellbeing. How does this apply to pregnancy? Certainly, from the beginning in many subjects there is a series of abnormal sensations or symptoms essentially unpleasant, worrying or painful. To enumerate a few: nausea, vomiting, sleepiness, tiredness, constipation, shortness of breath, striae gravidarum, oedema, backache. It reaches a climax in the delivery with all the pains, the bleeding, the tears that accompany it and furthermore, as late complications, prolapse, cystocele and rectocele. I will not include in this enumeration, although it could be considered, the specific complications of pregnancy such as miscarriage, placenta praevia, abruptio placentae, toxemia or the multiple complications of labor which demand delivery by cesarean section, nor postpartum psychosis. As time goes on, and the pregnancies are more numerous, the risk to the health of the mother gets to be greater and greater, so that by the tenth birth the mortality rate is five times the usual one. Of 29 maternal deaths in the state of Missouri in 1968, 12 happened in women who had more than five pregnancies; these findings are the same everywhere. The maternal deaths, which are directly related to complications secondary to great multiparity, would be very much reduced if contraception was used.

So pregnancy is not supposed to be a disease, yet I don't know how to define a state which brings about so many unpleasant symptoms and so many dreadful complications. I know of no other function in the human being which is so threatening for the individual. A woman who asks for an abortion or a sterilization feels that the pregnancy is threatening her wellbeing, maybe her physical wellbeing but, most often, her psychological and social wellbeing. As a woman I have been more attuned to this feeling than many of my male colleagues could ever be, because they can not feel as threatened as a woman can be by pregnancy and they can not identify themselves as closely with the patient. Our society considers it the right of everybody to protect himself from serious threats. Physicians, although they knew it was medically indicated, have been indifferent or definitely hostile to contraception and to abortion. As a rule, the medical profession is made up of conservative and conformist beings. It does not count many intellectuals or many revolutionaries; it is mostly composed of technicians. Our intellectual evolution has not come from the push of internal conviction but by the pressure of public opinion. As an example, may I quote the absence of statements from the profession on the hygiene and safety of workers before the unions imposed their corrective policies. Also, let's remember that the American Medical Association once opposed obligatory vaccination against smallpox, the establishment of blood banks, the intervention of the Federal Government in the construction and founding of medical faculties and help to students, that it opposed government subsidies to reduce maternal and infantile mortality and any form of social security. Physicians have left medical philosophy to be elaborated by people outside of medicine. I think it is time that they look to their own thoughts, that they dissociate themselves from a philosophy and a morality which aims to subject women to their biologic destiny, by law if necessary.

A very good gynecologist, consulted on what was to be done about a patient who, without any known pathology, had had nine successive miscarriages, more complicated each time and needing more and more blood transfusions, refused to sterilize her. To those who objected, because of the dangers incurred by the patient, he answered: "What can we do, it is the destiny of women!" This attitude of resignation based on "destiny", is contrary to the reason of existence of medicine which is to help people fight an ill-fated biologic destiny. As gynecologists, we are committed to see that every woman who ventures into pregnancy does so of her own free will, with a realistic knowledge of the danger inherent to the situation and with the opportunity of defending herself against them so that every birth becomes a desired and happy event. □

DOCTORS

The Medical Society suggests that you make the Bulletin available to your patients in your waiting room.

Therapeutic Abortion and its Complications in Halifax, N. S.

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and
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Little has appeared in the way of clinical studies of therapeutic abortion and its complications in Canada[2,3] since the law was changed on June 27, 1969. Much has been published in the world literature on this subject, particularly in recent years[1-16], but the reports have varied widely from country to country, and even from physician to physician. It is impossible to make inferences from these statistics.

This paper is an attempt to analyse a number of parameters of therapeutic abortion and its immediate complications in a Canadian city with a metropolitan population of 250,000. The makeup of the population undergoing therapeutic abortion, the complications of the procedure, and the social effect of the ever-increasing number of therapeutic abortions will be examined.

Materials and Method

The hospital charts for all therapeutic abortions performed in the Victoria General Hospital, the only hospital in Halifax, N.S. performing therapeutic abortions, from January 1, 1970 to December 31, 1971 were reviewed. These years were chosen as they were the first complete years since the enactment of the new law. Information from the charts was transferred to a questionnaire and then subjected to computer analysis.

Since one of the major difficulties with different studies has been the varying opinions as to what constitutes a complication, the following were the classifications defined and used in this particular study: Minor complications: hemorrhage necessitating one unit of blood, cervical laceration, other (specified); Major complications: hemorrhage necessitating two or more units blood, uterine perforation, pelvic inflammatory disease, readmission (or admission after an outpatient procedure), anesthetic complications, and other (specified). Retained products after a saline induction necessitating currettage was not considered a complication if the subsequent currettage was without problems.

To evaluate the social effect of therapeutic abortion, data were collected for the number of admissions for spontaneous abortions and the number of illegitimate births. It is felt that at least a portion of the admissions for spontaneous abortion, especially septic abortion, are in reality illegal, induced abortions, and therefore a decrease in these admissions would indicate the effect that legal abortion has on reducing the illegal abortion rate. The illegitimate birth rate is some indication of the number of unwanted pregnancies, and it might be expected to decrease if these pregnacies were being legally terminated rather than carried to term.

Results and Discussion

Table I shows the demographic characteristics of the sample. The number of therapeutic abortions almost doubled in 1971, from 204 to 429. Preliminary analysis of the figures for 1972 indicate that this increase is continuing. Nearly an equal number were performed as an outpatient procedure as were performed as an inpatient procedure, and this number increased from 1970 to 1971 as more patients applied earlier in their pregnancies.

TABLE I

Medical and Demographic Characteristics

	No.	%
Therapeutic abortions		
1970	204	32.2
1971	429	67.8
Total	633	100.0
Service		
Inpatient	344	54.3
Outpatient	289	45.7
Marital Status		
Married	217	34.3
Other	416	65.7
Age		
20 years or less	209	33.0
21 to 30 years	267	42.2
31 to 40 years	126	19.9
41 years or more	31	4.9
Median age 23 years		
Parity		
Nulliparous	329	52.0
Parous	304	48.0
Indication		
Medical	36	5.7
Psychosocial	597	94.3
Duration of gestation		
10 weeks or less	347	54.8
11 to 12 weeks	149	23.5
13 to 15 weeks	47	7.4
16 weeks or more	90	14.2
Median duration of gestation 10 weeks		

*Third Year Medical Student, Dalhousie University. This study was carried out as an elective.

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TABLE II

Operative Procedures

	No.	%
Type of procedure		
Vacuum currettage	345	54.5
Dilatation and sharp currettage	19	3.0
Sharp and vacuum currettage	120	19.0
Hysterotomy	14	2.2
Hysterectomy	60	9.5
Saline	75	11.8
Sterilization		
Tubal ligation	52	8.2
Hysterectomy*	61	9.6
Total	113	17.9
Anesthetic		
General	390	61.6
General and paracervical block	167	26.4
Paracervical block	3	00.2
Local	75	11.8

*One hysterectomy was done following a uterine perforation.

TABLE III

Complications

Complications	No.	% of complications	% of total cases[1]
Morbidity (indicated by a temperature of 38°C or more for two or more days)	10	10.6	1.6
Minor complications			
Cervical laceration	21	22.3	3.3
Urinary tract infection	13	13.8	2.1
Infected incision	1	1.1	0.2
One unit of blood	3	3.2	0.5
Total	38	40.4	6.0
Major complications			
Uterine perforation	5	5.3	0.8
Two or more units blood	9	9.6	1.4
Pelvic inflammatory disease	4	4.3	0.6
Anesthetic complications	3	3.9	0.5
Readmission for			
PID	7	7.5	1.1
Hemorrhage	1	1.1	0.2
Incomplete abortion	5	5.3	0.8
Pain	1	1.1	0.2
Vault abcess	1	1.1	0.2
(Total readmission)	(15)	(16.0)	(2.4)
Admission after outpatient procedure	6	6.4	0.9
Thrombophlebitis[2]	1	1.1	0.2
Septicemia[3]	1	1.1	0.2
Hemorrhage necessitating hysterectomy	1	1.1	0.2
Total	46	48.9	7.3
Total all complications	94	100.0	14.8
Total number of cases suffering complications[4]	75	100.0	11.8

[1] i.e. the percent of total cases having this complication.

[2] indication for therapeutic abortion was thrombophlebitis.

[3] indication for therapeutic abortion was leukemia.

[4] this number differs from the total number of complications because some cases had more than one complication.

Throughout the two years approximately twice as many patients were classified as unmarried (i.e. single, widowed, or divorced) as married. The median age was 23 years, with a span from 12 to 47 years. 75% of the cases were under 30 years of age. Over one half the patients had had no previous pregnancies. 78% of the terminations were performed at twelve weeks or less, and only 5.7% were performed for medical indications, with the rest being performed for psychosocial reasons.

Table II shows the operative procedures performed, and in keeping with the relatively early termination of most of the sample, currettage in one form or another accounted for 76.5% of the operative procedures. Tubal ligation accounted for somewhat less than one half of the sterilization procedures, which were performed on one fifth of the patients. General anesthetic was used in all cases except saline inductions, and was combined with a paracervical block in 26.4% of the cases.

Table III shows the complications that occurred. The total number of complications is larger than the number of cases suffering from complications, because some had more than one (e.g. a perforation of the uterus with rupture of the bladder, necessitating hysterectomy and several units of blood). Those classified as "Major" accounted for half the complications.

TABLE IV

Medical and Demographic Characteristics of Cases with Complications

	No.	%
Therapeutic abortion		
1970	24	32.0
1971	51	68.0
Total	75	100.0
Service		
Inpatient	50	66.7
Outpatient	25	33.3
Marital status		
Married	34	45.3
Other	41	54.7
Age		
20 years or less	21	28.0
21 to 30 years	30	40.0
31 to 40 years	18	24.0
41 years or more	6	8.0
Median age 26 years		
Parity		
Nulliparous	28	37.3
Parous	47	62.7
Indication		
Medical	6	8.0
Psychosocial	69	92.0
Duration of gestation		
10 weeks or less	31	41.3
11 to 12 weeks	17	22.7
13 to 15 weeks	13	17.3
16 weeks or more	14	18.7
Median duration of gestation 12 weeks.		

TABLE V

Operative Procedures of Cases with Complications

	No.	%
Type of Procedure		
Vacuum currettage	30	40.0
Dilatation and sharp currettage	1	1.3
Sharp and vacuum currettage	13	17.3
Hysterotomy	6	8.0
Hysterectomy	19	25.3
Saline	6	8.0
Sterilization		
Tubal ligation	10	13.3
Hysterectomy*	20	26.7
Total	30	40.0
Anesthetic		
General	55	73.3
General and paracervical block	14	18.7
Paracervical block	0	00.0
Local	6	8.0

*One hysterectomy was done following a uterine perforation.

Further analysis of the cases suffering complications was done, and this is shown in Tables IV and V, which correspond to Tables I and II for comparison. A larger number of complications occurred in inpatients, the median age was higher and nearly 36% were of 13 weeks gestation or more, compared with 21% of the entire sample. Primarily this is because hysterectomy and hysterotomy are usually performed on an inpatient basis on older women who are further advanced in their pregnancies, and these two procedures are associated with a much higher complication rate. 33.3% of the complications had had a hysterectomy or hysterotomy versus only 11.7% of the total. Fully 40% of the complications had had some form of sterilization procedure.

Table VI shows rates of complication. The rate of complication increased with age, duration of gestation and parity. Hysterectomy and hysterotomy had by far the highest complication rate. It is worthy of note that the second most frequent complication, urinary tract infection, occurred solely in cases having one of those two procedures. Most of the rates determined for duration of gestation versus procedure are based on too small a sample, but there seems to be an increase in complications with an increase in duration for all procedures, particularly in the case of currettage.

In this study saline induction was singularly free of complication, having a lower rate of complication than any other procedure excepting sharp currettage. In most other studies, which report a higher incidence of complications for saline, retained products necessitating currettage was considered a complication. For the purposes of this study, uncomplicated currettage was not so considered. Actually only a very small number of patients needed further instrumental evacuation.

Sterilization also carried an increased complication rate, more than double that of the sample as a whole.

TABLE VI

Rates of Complication

	No. of complications (cases)	N[1]	Rate/100
Demographic characteristics			
Year			
1970	24	204	11.8
1971	51	429	11.8
Total	75	633	11.8
Service			
Inpatient	50	344	14.5
Outpatient	25	289	8.7
Marital status			
Married	34	217	15.7
Other	41	416	9.9
Parity			
Nulliparous	38	329	8.5
Parious	47	304	15.5
Indication			
Medical	6	36	16.7
Psychosocial	69	597	11.6
Age			
20 years or less	21	209	10.0
21 to 30 years	30	267	11.2
31 to 40 years	18	126	14.3
41 years or more	6	31	19.4
Duration of gestation			
10 weeks or less	31	347	9.0
11 to 12 weeks	17	149	11.4
13 to 15 weeks	13	47	27.7
16 weeks or more	14	90	15.6
Procedures			
Type			
Vacuum currettage	30	345	8.7
Dilatation and sharp currettage	1	19	5.3
Sharp and vacuum currettage	13	120	10.8
Hysterotomy	6	14	42.9
Hysterectomy	19	60	31.6
Saline	6	75	8.0
Anesthetic			
General	55	390	14.1
General and paracervical block	14	167	8.4
Paracervical block	0	1	0.0
Local	6	75	8.0
Sterilization			
Tubal ligation	10	52	19.2
Hysterecotomy[2]	20	61	32.8
Total	30	113	26.5
No sterilization	45	520	8.7

[1] N is the number of cases (total) in this category.

[2] One hysterectomy was done following a uterine performation

The data pertaining to social impact is summed up in Table VII. The figures for spontaneous abortion admissions were obtained from the two hospitals in Halifax which received those patients. There was a drop in the number of

admissions for spontaneous abortion in 1971, with a particularly noticeable drop in the septic abortion rate. Data from the coming years will be needed before it can be shown that this is truly a downward trend, and not just a chance occurrence.

The number of illegitimate births increased in 1970 and 1971, but in 1971 they made a noticably smaller percentage of the total live births. While there are many factors other than abortion (e.g. birth control, changing attitudes of society to unwed mothers, an increased population at risk, etc.) affecting the illegitimate birth rate, this decrease might be due to the increasing number of illegitimate pregnancies being terminated. In sum, it is probably too early to tell if there has been much impact, as the total numbers involved are quite small.

In Table VIII we have tried to show the large variation in rates of complication found in various studies, and to indicate approximately how this study fits in. Much of the difference in rate is probably more apparent than real, for a study which relied on discharge reports rather than on actual perusal of the operative reports for a determination of the complications would overlook many.

In summation, the immediate complication rate of therapeutic abortions performed in a hospital setting found in this study was 11.8/100. The rate increased with increasing duration of pregnancy, and increasing complexity of procedure. Concomitant sterilization also added considerably to the risk. One point that is particularly noteworthy is that therapeutic abortion on an outpatient basis in cases of 12 weeks gestation or less can be performed by vacuum aspiration with a complication rate of only 8.7/100, in which the majority of the complications are minor. As more data becomes available on a larger number of cases, we should be better able to evaluate the effects of a relatively unrestricted abortion law on the immediate health of the women concerned, and on society. □

TABLE VII

Spontaneous abortions and illegitimate births in Halifax

Spontaneous Abortions

	1967	1968	1969	1970	1971
With sepsis[1]	19	19	17	17	10
Total	445	413	397	420	379

Illegitimate Births[2]

	1967	1968	1969	1970	1971
No. of illegitimate births	267	278	347	351	654
% of total live births	18.0	19.1	16.2	15.6	12.4

[1] Separate figures for this category were available for only one of the two hospitals from which figures were obtained (Victoria General Hospital, the Halifax Infirmary).

[2] The figures to 1970 are from the Bureau of Vital Statistics, while the figures for 1971 were obtained from the two maternity hospitals in Halifax, Grace Maternity Hospital, and the Halifax Infirmary.

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(References continued on page 75.)

TABLE VIII

Comparative Complication Rates of Therapeutic Abortion (rate/100)

	Overall	D & C	Vacuum	Saline	Hysterotomy	Other
Halifax, 1970-71	11.8	10.1[1]	8.7	8.0	42.9	31.6
Tietze(16) USA 1971		6.4	4.7	22.1	35.7	
Smith(13) Hawaii 1970	4.1	2.0	3.0	5.0	50.0	40.0–
Jurukovski(8) Yugoslavia 1965-8	4.3	4.8	3.9	4.4	–	–
Olsen(12) Denmark 1961-6	4.7	5.4	not used	4.5	2.5	–
Parker-Nelson(4) NYC 1971	8.5	5.9	4.4	31.6	34.3	7.0
Stallworthy(14)[2] Oxford 1971	88.9	72.5		124.2[3]	97.1	134.0

[1] this includes sharp, and sharp and vacuum currettage.

[2] the figures are calculated on total complications, not cases suffering complications, and therefore the rate is sometimes over 100.

[3] included in this number are all pharmacological inductions, including glucose instillation aminacrine, and prostaglandins.

REVIEW OF NOVA SCOTIA

HEALTH COUNCIL REPORT

Through A Glass Darkly

The Health Council Report

Introduction

The Medical Society of Nova Scotia has reviewed the report of the Nova Scotia Council of Health to government. The following observations are by no means a critique of the entire report but they do deal with several of the document's basic premises. The major issues of concern to the medical society are considered as follows:

1) We doubt that the province's health care system is, in fact, facing a crisis.

2) There is concern that the formation of a new bureaucracy through community and regional health boards will lead to increased costs and inter-community competition for facilities and services for reasons other than real need.

3) We believe that Nova Scotia can be administered as a single health care region *and* retain valuable citizen counselling and problem solving in-puts.

4) It is our firm belief that the basic value of the community hospital trustee set-up as it relates not only to community service but also to the equitable distribution of medical manpower has not been recognized.

5) We believe that the community health centre concept as proposed has potential disadvantages.

6) The potential for service fragmentation will be a consequence of several of the recommendations in the report.

Observations

While the report's preamble calls for the recognition of a "crisis" situation in Nova Scotia's health care system and states that the only way to avoid this is to change the system, many of the steps it recommends are questionable.

A key set of recommendations deals with the formation of community and regional health boards with budgetary and planning responsibilities. Five regions are defined.

There are several reasons for doubting the worth of this proposal. If the health delivery system is facing a financial crisis – as the report states – the establishment of a new and more complex bureaucracy to deal with it will not lessen the drain on public monies and is unlikely to place any controls on cost escalation regardless of the report's contention that the community and regional health boards will have to recognize a form of "health resources trade-off" approach.

The report's authors may have thought that a spin-off benefit from the various health boards would be a greater public understanding of how to use the system to best effect. Instead, what may happen is that decisions will be taken at the local and regional levels which will reflect personal or small group preferences without regard for the overall system.

Without in any way attempting to impugn the motives of any future board members, inter-community competition for facilities and services could lower the quality of health care and increase its cost. In fact, there is cause for concern that the proposed bureaucracy could result in the misdirection of health dollars.

The report also refers to the community health board as the "employer". It is doubtful if health professionals will accept this ethic, implying as it does a potential for regimentation of both physicians and their patients with subsequent restrictions on a physician's ability to fulfill his responsibility to his patients and the patients' right to receive care.

The report notes that each health board would have its own administrative staff. Quite apart from the new cost element involved in this recommendation, where will the expertise come from?

And looking at costs, particularly when one considers the type of administrative and medical co-ordinating expertise required, it is not difficult to conceive of new annual costs of at least $3 million for administrative expenses alone at the community and regional level.

The health boards themselves will be subject to political pressures at the community level – the type of local pressures which are difficult to ignore but which can be better handled at the provincial level because of the natural checks and balances brought into play by broader considerations.

As conceived, the community health boards could also become influential lobbies which could work against the overall priorities of the provincial Department of Health.

Of course, the formation of some 40 new bureaucracies throughout the province will create delays in the decision-making process notwithstanding the recommended streamlining at the top.

The Medical Society has always held that Nova Scotia is simply too small to be divided into five regions. It is, in fact, a region in itself. But the Medical Society recognizes the need for citizens at all levels of the community to participate and contribute to an improving system.

This can best be done – and the negative effects of fragmentation avoided – by treating the province as a single

region under a single regional health board made up of representatives from the various communities and geographic areas of the province, taking special care to include representation from various voluntary health service groups such as Mental Health Nova Scotia, the Heart Foundation, the Canadian Red Cross and many others. Such groups have provided invaluable health service in the past and must be included in any future planning and implementation. Community participation can be enhanced by the community itself electing a representative to this single regional health board.

The Medical Society agrees with the report's concept of regional referral hospitals but great care must be taken to recognize the value of existing smaller community hospitals and the services they provide. In structuring what we hope will be a better health delivery system we cannot ignore the potential for harm of unnecessary patient dislocation which has both medical and financial ramifications. We must not forget that our community hospitals are in existence today because the communities themselves recognized a need, organized the administrative skills available in each community, sought capita cost financing and developed their own hospitals. The system has worked, is working and should not be jeopardized on purely administrative grounds without consideration of both the medical and social impact on each community involved in change.

One area not considered in the report is the need for the proper machinery and funds to help reduce institutional per diem patient costs. Ideally, convalescent patients can be taken care of in registered nursing homes and convalescent centres with costs being met through the overall provincial health budget instead of through the Department of Welfare. To make this possible, some legislative changes are required to ensure the adequacy of these nursing homes for this purpose.

The report's recommendations on ambulance services deserve broad support. We do need a centralized ambulance control system to prevent duplication in the service and the facilities as well as the kind of assistance which will allow ambulance operators to upgrade their service.

By and large, a concerted effort should be made to provide normal out-patient services in a more orderly fashion. Ideally, these services should be provided in the physician's office with hospital out-patient referrals only for those procedures which a hospital is especially equipped to perform. This does not mean, however, that a physician should not see a patient in the out-patient department when mutual considerations of time and distance dictate that this would be the proper use of manpower.

Hospital emergency departments should be for emergencies only. Obviously non-emergency cases should be promptly referred to the out-patient department on an appointment basis. Elective primary care is not an emergency department function.

While the progressive care concept is an ideal to be sought, if the system is currently facing a financial "crisis" then some tough thinking has to be done in setting the projected costs of a patient's progress through a series of units and services against what we know about today's per patient costs. Current trends are to adapt services in a single unit of care to a recuperating patient's less complex needs. The Health Council report implies that the patient should now be moved through several units as his needs lessen in both complexity and frequency of service. The Medical Society certainly supports the concept of, for instance, the combined nursing home and convalescent unit which will free hospital beds for active treatment needs and recognizes the psychological as well as the financial benefits of home care. However, what will it cost to move a patient through this cycle?

The point should be made now that the experts in home care planning and management as well as in the actual delivery of service are, in fact, members of the Victorian Order of Nurses. To a large extent the Health Council's report recognizes this. However, it again recommends that VON services be based on an employer-employee relationship with the community health board which, operating on a fixed "global" budget, will have to make decisions as to whether or not it can afford a home care program as set against, say, a new nursing home. The possibility of service fragmentation and differences in the type and quality of service from community to community does raise some questions about the report's intention to co-ordinate services and to improve accessibility on a province-wide basis.

The Health Council has also tended to opt for the community health centre as an integral part of the health care picture. The availability of 24 hour service through such a centre can demand six persons for each professional position. This manpower demand may be ameliorated somewhat by an after 10 p.m. call roster as opposed to full 24 hour service but costs will still be high. The capital investment is another consideration. Doctors themselves are tending toward high service capability group practices which, in fact, can be considered community health centres. Excellent examples of this type of group practice community medical service facility have recently been opened in Nova Scotia in which physicians have assumed mortgage responsibilities – in exactly the same manner they have always done – but it is doubtful if this private funding approach can be encouraged if, as the report suggests, physicians are to be considered employees of the community health board which, according to the report, would play a large part in the "rationalization" of the system and "... changes in the role of the doctor, where and how he practices."

One particular problem not touched upon by the Health Council report is the somewhat discriminatory tax law which inhibits physicians from building their own clinics. Currently, physicians cannot claim for capital cost allowances in the construction of these clinics. It does seem a little contradictory that while decrying the over-utilization of hospital emergency and out-patient departments, current

tax laws are designed to discourage physicians from investing in the types of complementary facilities which would ease the over-utilization and reduce costs.

The Health Council has recommended a variety of developments which, if initiated, will most decidedly affect patterns of practice. The doctor's traditional role has been to practice independently, or with a group of physicians, or in the appropriate institution, or, eventually, to forego all or a part of his practice in order to train more doctors. One key consideration has been whether or not a particular geographic area can sustain a physician. The advent of MSI has not changed this. However, the introduction of more regimentation, of more administrative bodies with authority to make decisions on patterns of practice may.

A reallocation of priorities at the regional or community level could result in the dislocation of certain physicians with certain skills. They will have to establish practices elsewhere. There is no guarantee that they will remain in the province. Neither is there any guarantee that physicians who feel they cannot serve their patients' needs under the direction of a community or regional health board will stay in their practice or in Nova Scotia.

Currently, Nova Scotia has the second lowest per capita health costs in Canada. But in terms of physician manpower, the province is competitive and it does attract physicians from elsewhere. Serious thought must be given to the possibility that in attempting to restructure our health delivery system we do not over-structure it and discourage physician "imports" or encourage practising physicians to leave.

The Medical Society of Nova Scotia and doctors generally want to see the availability and accessibility of health services expand. In its brief to the Health Council the Society pointed out that it is important to determine where and what the province's overall and specific needs are before planning and implementing steps to meet those needs.

As the Health Council itself has stated, costs are an important consideration. Obviously then, we need to get a cost/benefit picture as it applies to the best health care possible for all Nova Scotians. The report has not done this, except in that it has called for a form of continuing review. Surely, we must determine now what percentage of the health dollar is spent on what particular service or operation. Where the cost of administering MSI is concerned, the province has already achieved considerable savings through the use of Maritime Medical Care's inherent private-public flexibility. This should continue. In fact, in Maritime Medical Care we have the tool through which it is possible to take the first definitive steps in assessing quality and utilization factors. In other areas of the system, the picture is less clear.

Perhaps a detailed picture of the health dollar breakdown along with careful study of the Health Council report and all its implications by all concerned should be a prerequisite before demanding that "the system must change." □

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Physician Self-Assessment – ANSWERS

Question No.	Correct Answer
263	C
264	C

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The Use and Abuse of Drugs in Psychiatric Out-Patient Therapy†

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This paper elaborates on one aspect of the work mentioned in "A Critical Appraisal of Some Aspects of Out-Patient Care"[1] which described briefly some difficulties encountered in the use of drugs in an out-patient department dealing largely with patients of the lower socio-economic group.

The psychiatric literature on drugs is massive but there are relatively few papers on the very important subject of patients who deviate from the regime that is ordered for them. Michaux[2] studied the interrelationship between side-effects, resistance and deviation from prescribed dosage. Resistance to therapy and dosage deviations were positively correlated and were both, like side-effects, unrelated to the kind of medication received. The relation between side-effects and dosage deviation was positive and significant.

Raskin[3] compared deviators and non-deviators and found there was no difference in reported side-effects between the two groups. The deviators were better educated, had more knowledge of psychiatry and had less favourable attitudes towards physicians than the non-deviators. The deviators were judged by their therapists to be more hostile and resistant to psychotherapy. Richards[4] found that deviators or "refusers" had a negative attitude towards medicine, but felt more warmly towards the hospital. Refusers held more negative attitudes towards home, family and authority.

Other studies utilizing blood and urine drug levels have established that, even in hospitals, patients frequently do not take drugs as ordered.[5]

The use of prescribed drugs was studied in a random sample of 100 out-patients seen over at least a 12-month period using a detailed questionnaire, review of the chart and, in some cases, home visits to count the drugs in the patient's possession. Areas investigated were the educational and economic level of the patients, their diagnoses, number and types of drugs used, number of changes in medications, side-effects, patients' attitudes towards the drugs, their knowledge about the drugs they took, deviation from the prescribed dosage and the disposition of their unused drugs. Some of the findings are described below.

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An obvious source of error in such a study is its subjective nature. One of the most striking features noted in questioning these and other out-patients about their drugs is the frankness with which they describe various types of deviations, including giving drugs to others, storing large amounts of drugs, etc. To our surprise, the patients did not seem to feel that their deviant use of drugs was anything to be too uncomfortable about. If the data obtained does not represent the full amount of deviation, it is nevertheless significant; the true deviation must be even greater.

Of the 100 out-patients, 35% were diagnosed as having neurotic reactions, 34% schizophrenia, 10% affective disorders and 19% personality disorders. Drugs prescribed included the major and minor tranquilizers, anti-depressants, sedative-hypnotics, and antiparkinson agents. An average of three drugs had been prescribed at any one time with approximately four changes in drugs over a 1-year period per patient; 61% reported side-effects from the drugs as a whole; 93% thought the clinic was helpful, with 31% feeling the doctor of most value. It should be noted that more than half the patients reported that they spent less than 15 minutes with the doctor.

Some kind of deviation in taking the drugs was described by 56% of the patients. Forgetting equal to or greater than 15% of the time was considered to be deviation. The commonest type was to discontinue the medication (35%) for varying lengths of time or to reduce the dosage (17%). Many reasons were given for this; e.g., feeling better, fear of addiction, a desire to see how they could get along without the drug, a response to delusions or hallucinations or a reaction to excessive side-effects. One patient said, "A voice told me to take all the pills. It was too hard to fight the voice so I burned all the pills." Another discontinued her drug because she "thought there might be LSD in them."

35% of patients increased the dosage without the doctor's knowledge. These patients usually believed, sometimes accurately, that their symptoms would improve with a higher dose. Sometimes, however, such increases led to peculiar consequences. One man, a tense alcoholic, on Chlorpromazine 100 mg. at bedtime became depressed and raised his does to 100 mg. four times a day. His depression was unchanged but extreme restlessness, probably a side-effect, complicated the picture.

Another common pattern was to give or accept drugs from others. 20% of the deviators had recommended their drugs to others and 10% had actually given the drugs to

someone else. One 69-year old woman gave her tranquilizers to her grandchildren when they were nervous and saw nothing wrong with this practice. Still another patient said, "I bummed all kinds of pills from anybody who would give them." Many described ambivalence about the drugs with a variety of concerns resulting in sudden changes in dosage, often related to comments about drugs on the news media or from friends.

All patients were asked about the quantity of medicine they had at home. Those estimating amounts in excess of what one would expect, considering the amounts prescribed, were asked to bring in their drugs to be counted and a further seven in the area were selected for home visits. These were co-operative and did not appear to regard these visits as intrusions. The data obtained did not support our suspicions that many patients had accumulated large amounts of drugs. However a few people did have large amounts of drugs obtained from the psychiatric and other clinics. Some of these had continued to accept their drugs knowing that they would not take them. In one instance, a patient had stored hundreds of many kinds of pills throughout the house, even under the mattresses.

Although a variety of other data about patients who deviate was statistically significant, little new insight into the nature of deviators was derived. The highest percentage of deviators fell diagnostically into the neurotic category, with schizophrenia, affective and personality disorders following in decreasing order. This is not what one would expect and the explanation is not clear.

Deviation was not, apparently, related to the type of medication, the number of different drugs received, the number of changes in the drugs or the number of doctors each patient had seen. There was no significant difference in the educational background or performance level between the two groups. However, 75% of the deviators spent 15 minutes or *less* with the doctors in contrast to 48% of the non-deviators. Obviously many possible explanations; e.g., patient selection, doctor-patient rapport, etc., contribute to this finding.

Non-deviators believed in the use of drugs to a significantly greater degree than deviators (89% compared to 71%). There was a positive correlation between side-effects and dosage as described by Michaux.[2]

As a comparison, using a different population group, 18 students seen by psychiatrists at the University Health Service and on medication for at least part of the time were surveyed by the questionnaire. In contrast to the clinic out-patients, most of these patients belonged to Class I to III according to Hollingshead's criteria. Diagnostically 78% presented with neurotic and/or personality disorders, while 22% had psychotic reactions. The patients were seen over a 2-year period at most with an average of 26 visits per patient. Most were seen for at least 45 minutes each session and by the same psychiatrist during their entire course of therapy.

While in treatment, 2.7 different drugs were used per patient and at any one time each patient was receiving 1.5 drugs. All the psychotropic drugs were used, although the anti-depressants were less common. While three-quarters of the patients reported that the drugs were of some help, none found the drugs more helpful than the psychotherapy and 50% noted some unpleasant side-effects. The students were quite knowledgeable about their drugs, and usually were able to name their medication specifically as well as their intended effect.

Like the clinic out-patients, the students were quite open in discussing their use of the medications. Fifteen or 83% reported some deviation from the prescribed dosage. Eleven had either stopped or reduced the dose of their pills without consulting the psychiatrist because, "I did not need them," or "I can regulate it (dosage) better; I boobed sometimes." Of these, the changes were justified in four. Five patients or 27% gave their drugs to others and two students took over-doses repeatedly.

It is apparent from these statistics that although social class, education and a more consistent and intensive doctor-patient relationship may reduce the number of drugs used, the amount of deviation in drugs usage is unaffected.

Review of the out-patient clinic charts was undertaken to observe the patterns of drug usage by the doctors but unfortunately, to our surprise, while they provided fairly detailed progress noted about the patient's life situation, they gave little information about the effects of the various drugs on a particular patient or reasons for changes in medications. However, both the charts and observations in the clinic did reveal a variety of unsatisfactory patterns of drug use by the physicians.

Anti-depressant drugs were used excessively, probably because most psychiatric patients are unhappy and most clinic patients had not responded dramatically to other drugs. Often initial doses or drugs were too large and produced too many and too severe side-reactions in patients with idiosyncrasies. At other times the dosage was not raised to full therapeutic levels so that the efficacy of the drug was not accurately assessed. There was a marked tendency to continue a drug indefinitely when it was of questionable benefit or might produce habituation. Extrapyramidal side-effects were often treated by larger doses of anti-parkinson drugs than necessary without regard to their own significant side and toxic effects. Excessive use of manufacturers' mixtures of drugs and curious combinations of all kinds which seemed to have no therapeutic rationale were common.

Many patients had a problem which was, in a sense, the opposite of deviation and had come to feel that their particular drug regime was ideal and must never be changed. One patient, on several psychotropic drugs, had also managed to remain for many months on anti-histamines and both liquid and solid gelusil which he no longer needed. He became hostile and aggressive when a change was suggested. When a new brand of a known drug with a different appearance was introduced, complaints about the

"new" drug's ineffectiveness and side-effects occurred. Although some of these might have been due to actual chemical differences, the variations in complaints suggested otherwise. The patients often required a great deal of support before accepting the new brand.

A variety of other deviant drug behaviours in the psychiatric clinic and other hospital and community clinics have been noted and a few examples are worth mentioning. Several of our patients, in spite of apparently adequate warnings, have taken large amounts of alcohol with Parnate and one had a severe hypertensive reaction. One man on Parnate for some time told us on specific questioning that he loved pickled herring, chicken liver and wine and continued to ingest as much of these as he could. Another patient, not psychotic and of average intelligence, told of taking her total dose of Librium, four capsules, at once so that she would not forget any.

Many out-patients who are pleased with the effect of their tranquilizers tend to get as many as possible from each of the many specialty clinics they attend. The doctor in each clinic must, therefore, be on the lookout for this. One of our patients gathered enough pills to tranquilize many of the patients at the nursing home where she lived and took so much herself, apparently without intending suicide, that she was admitted to hospital in a stupor. Still another accumulated sufficient sleeping pills from the various clinics to take addicting doses.

Even the route by which the drug was to be taken became confused. One woman complained bitterly at the Ear, Nose and Throat Clinic that her nose was burned by the medicine she received at the medical clinic, which turned out to be potassium iodide drops. Another patient sold a number of her contraceptive pills, one to each friend informing them that one was effective, and some unwanted pregnancies resulted.

Summary and Conclusions

A survey by questionnaire of the drug habits of 100 randomly selected psychiatric out-patients and observations of drug use and abuse by patients in the clinic are described. A small series of university students in psychiatric treatment was studied similarly. The patients were surprisingly frank in describing deviant use of drugs.

Over half of the patients did not take the drugs as ordered. High risk drugs or those requiring unusual precautions cannot be used safely with such patients. Patients must be asked regularly about the details of their drug consumption; it must never be assumed that they are taking the drugs as ordered. Seriously ill patients needing, but not taking, drugs as ordered will require special efforts utilizing relatives and public health nurses to adequately supervise their medication.

Observations of common types of misuse of drugs by the medical staff are also described. □

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A Report on Epidemic Influenza in the Maritime Area in 1973[†]

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Epidemiology

Specimens of throat swabs and/or saline garglings have been received from approximately 170 individuals.

As far as we have been able to ascertain, the disease has tended to attack young adults in previously good health. Children of school age appeared to have been less affected, according to absenteeism reports.

Virus Isolation

Pending confirmation, 46 influenza virus strains have been isolated from the 13th January to 27th February, 1973. An additional eleven cases have been identified serologically as Influenza A.

Twenty-three of the 46 have been identified as being closely related antigenically to the A_2/England/42/72 virus. Subcultures of three strains forwarded to Dr. A. Frappier, at the Institute of Microbiology, Montreal, were duly confirmed as being of the England type. (See appended table).

Clinical Features

From information gathered from various sources, it would appear that the disease has a short incubation period of 24 to 36 hours. The illness is characterized by a sudden acute onset ushered in by headache, sore throat, cough, tracheo-bronchitis, general malaise, myalgia, and frequently high fever, lasting 3 to 4 days. Abdominal cramps and diarrhoea were noted in some instances. Recovery in uncomplicated cases is accompanied by a short period of weakness.

Deaths

During the period January 13th to February 27th, seven deaths (6 in N.S. and 1 in N.B.) occurred, in which viral influenza was suspected to have aggravated pre-existing disease or in which other forms of disability were superimposed on viral influenza.

CASE I. D.M. Woman age 21. This case was reported previously as having developed an acute attack of influenza lasting 3 days, with death thereafter. At autopsy, specimens of right and left lung tissue showed a growth of *Staph. pyogenes* and *H.influenzae.* Only pericardial exudate was available for virus studies, and from this material no virus was isolated. However, we would add that two personal contacts of D.M., (M.C. and J.S.) subsequently developed influenza and yielded A_2/England type virus.

CASE II. R.G. age 31, died at the V.G.H. following influenza, pneumonia and pre-existing chest complications. A_2/England virus was duly isolated in egg embryo culture from tracheal aspirate.

CASE III. E.T. age 79, who had a history of chronic respiratory insufficiency and coronary disease, subsequently developed fever, malaise, cough, shortness of breath and died. From throat washings A_2/England type influenza virus was isolated.

CASE IV. J.D. age 30. Died at St. Martha's Hospital, Antigonish. Autopsy revealed bilateral acute haemorrhagic pneumonia – reported by Dr. Mertens, Hospital Pathologist. A_2/England strain of influenza was isolated from lung tissue.

CASE V. K.M. age 47. Died at the Sutherland Memorial Hospital, Pictou. Dr. Stuart Dunn informed us that he considered acute viral influenza was the most probable activating cause of death in this patient, who had a previous record of debility with alcoholism. Lung tissue removed at autopsy was cultured for virus, but no virus was isolated.

CASE VI. McC. age 2½ months. (female) Amherst, was dead on arrival at hospital. No virus was isolated from lung tissue.

CASE VII. C.H. (Fredericton) had a recent history of influenza, bronchopneumonia, myocarditis and severe laryngeal oedema which was suspected to be of viral origin. No virus was isolated from lung and bronchus tissue.

Pathogenesis

To understand the initial and contributory causes of death following epidemic influenza, it is necessary to appreciate the basic nature and the ensuing sequence of events affecting the respiratory passages.

The most probable primary site for viral attack is the mucous membrane lining of the naso-pharyngeal, tracheal and bronchial spaces. Thus destruction of the epithelial lining of the tracheo-bronchial areas deprives the host of the first line of defense against microbial invasion. The process may be relatively rapid and the bronchial epithelium could be severely injured after 24 to 48 hours following an acute attack of influenza. Subsequently, regeneration of epithelial lining may occur with equal rapidity. Nevertheless, there does remain a period, however brief this may be in time, during which the bronchial

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	Typed Positives	Presump. Positives (& Doubtful)	Neg.	Under Study	Total (cases) received	Death	Serology Positive (pos. isol.)	Serology Positive (other than pos. isol.)
Kentville								
N.S. San	5		1	14	20		2	6
Truro			1	1	1			
Bridgewater	3				3			
Amherst			1		1	1–		
Antigonish	1				1	1+		
Pictou			1		1	1–		
Greenwood								1
Halifax –								
County Hosp.			1	5	6			
Path. Inst.	1		1	4	6	1–		
VGH Emerg.	4	2	1	9	16			
Prev. Med.	2	12	1	29	44			
I.C.U.		2	6	4	12			
Wards	4	3	3	10	20	1+		
Dal Student Health	1	3		8	12		1	2
St. Mary's Univ.	1	1			2			
N.S.I.T.			5		5			
Cdn. Forces			1		1			1
I.W.K.			2		2			
New Brunswick								
St. Johns	1		6	6	13			
Fredericton			1		1	1–		
Bathurst				2	2			
Newfoundland			1		1			1
TOTALS	23	23	33	91	170		3	11

passages, alveoli and capillaries are defenceless against attack from opportunist secondary invading bacteria.

Thus, bacterial invasion, which is prone to occur during this interval, may determine the outcome of a patient's illness since many normal individuals may harbor streptococci, straphylococci and occasionally pneumococci, during the winter months of the year.

The more widespread use of antibiotics among the population at large has done much to diminish the number of carriers of such organisms among different communities. Thus, to some extent, the risks of secondary bacterial invasion have been greatly reduced, but not entirely eliminated. Bearing these facts in mind, the impact of viral influenza on the unfortunate patient with a pre-existing chest disease, or pulmonary disability resulting from medical, surgical or other causes, poses a special problem. Extreme vulnerability to secondary bacterial invasion with liability to develop pneumonia, pleurisy, empyema, pericarditis and other complications, demand vigorous preventive measures and therapy. A history of alcoholism tends to make the prognosis worse.

Treatment

At the first signs of illness, the patient should retire to bed, take his or her temperature, morning, noon and night, and remain in bed until the temperature returns to normal. If fever remains elevated for more than 3 days, the patient should summon a doctor.

To prevent bacterial complications a good argument can be made for treating cases of influenza during the first 4 days of illness with a broad spectrum antibiotic such as tetracycline, giving 250 mg (q.4.h.) by mouth to afford protection against bacterial overgrowth.

Immunization

History repeats itself – and so do the same academic discussions recur annually with monotonous regularity, regarding the pros and cons of immunization against influenza. Sad to say, only too often the net result is to procrastinate and to delay vaccination until the epidemic has started.

To avoid panic and the rush to attempt immunization, it is advisable to give 1 dose of vaccine to selected groups of public employees and persons with a history of chest or lung disease, each year in September. This should be followed by the second dose 8 weeks later. True enough, antigenic variation or mutation of the epidemic strain may occur, but with the passage of time, the odds are lengthening in favor of persistence of variations of one or other of the A or B strains already encountered in the past. Existing strains used in the currently produced vaccines give a substantial degree of antigenic cross coverage. □

Amebic Liver Abscess in Nova Scotia

J. H. Haldane, F.R.C.P.(C), F.R.C.P. (Glas.), F.R.C.P. (Edin.), and J. R. Rae, M.D.

Halifax, N.S.

In 1949 the Canadian Medical Association Journal published an article on amebiasis in Veterans[1] which concluded: "It is to be expected that occasional veterans will be seen perhaps for many years hence, who develop amebic colitis or amebic hepatitis with or without abscess. The possibility of amebiasis should, therefore, be borne in mind when evidence of infections in these organs is encountered in veterans of World War II." The present case illustrates the need for continuing awareness of the possibility of this infection in temperate zones, an awareness that should be heightened by increasing Western involvement in areas in which amebiasis is endemic.

Case Report

In August 1968, a 72-year-old ex-serviceman of Latvian origin who had served in various Eastern European countries during World War II was admitted to the Victoria General Hospital with pyrexia of unknown origin. He escaped from Latvia in 1940, during the Russian Occupation, and served with an Eastern European army. From 1944 to 1953 he lived in Germany, and then emigrated to Canada and came to live in Nova Scotia. In August 1968 he was still working full-time as an accountant. He did not smoke, had not taken alcohol for the last 18 months, was not taking drugs, and had no known allergies.

His medical history included tuberculous pleurisy in 1921 and prostatectomy in March 1963. In October 1963, when he was admitted to the Neurology Service at the Victoria General Hospital for investigation of blurred vision in his left eye, no cause was found for a left visual field defect. In April 1968 he had been given physiotherapy to relieve joint pains. He had been taking Gelusil regularly for 'heartburn' since 1967, when roentgenography had revealed a hiatus hernia. There was no history of other gastrointestinal trouble. His weight had been steady at 175 lb. for years.

On admission he was complaining of lassitude, ready fatigue, pain behind the left ear, fever and sweating of 10 days' duration, and had had a dry cough with pain across the lower front of his chest four days previously. The patient was well nourished. He was anorectic but had not vomited, and bowel movements were normal. His face was flushed, temperature was 102.4° F. (39°C.), and he was sweating freely. The only abnormal physical findings were a left-sided visual field defect, kyphoscoliosis convex to the right with severe deformity and prominence of the posterior right side of the thorax, medium rales at both lung bases, more audible on the right side, and non-tender enlargement of the liver to I f.b. below the right costal margin.

Investigations and Course

Hemoglobin was 15 g.%; leukocytes totalled 13,725, later increasing to 19,525 per c.mm., with 85% polymorphs. Three smears were negative for LE cells. Coombs' test was negative and the bone marrow appeared normal, and cultures of blood, bone marrow, sputum and urine produced no growth of any organisms, including acid-fast bacilli. Urine analysis revealed nil abnormal, Bence–Jones protein was not detected, and electrophoresis patterns were normal. Paul-Bunnell test, Widal's reaction and complement fixation test for *Brucella abortus* and trichiniasis were negative. Serum creatinine, 1.5 mg./100 ml.; serum albumen, 38 mg./100 ml. Serum enzymes: glutamic oxaloacetic transaminase, 136 mU./ml.; glutamic pyruvic transaminase, 141 mU./ml.; and lactic dehydrogenase, 390 mU./ml. Total serum bilirubin, 1 mg. per 100 ml.; and serum alkaline phosphatase, 51 K.A. units. Bromsulphthalein testing showed 15% retention at 45 min. Total serum protein, 7.1 g./100 ml. (2.3 g. albumen and 4.8 g. globulin), and electrophoresis showed 36.8% albumen, 8.2% α_1, 21.0% α_2, 13.5% β, and 20.4% γ globulin. Serum immunoglobulins: 1750 mg. IgG, 420 mg. IgA, and 80 mg. IgM per 100 ml. ECG was normal. A chest roentgenogram showed patchy areas of consolidation at the right base and kyphoscoliosis.

Treatment was begun with penicillin G, 1 mega-unit q.i.d. Two days later a chest film showed no change in the consolidation but revealed a prominence suggestive of neoplasm at the right hilum. Bronchoscopic appearances were normal, and tomograms of the hilar area and roentgenographic search for metastases revealed no abnormality. Cholecystogram revealed nonfunctioning of the gall bladder and barium meal with follow-through showed a hiatus hernia, but barium enema, IVP and lymphangiogram revealed no abnormality.

Fever persisted despite a 10-day course of chloramphenicol, 250 mg. q.i.d. Liver scan showed enlargement, and diminished uptake in the superior aspect close to the midline. Liver biopsy showed reactive hepatitis of nonspecific type, with areas of hepatocellular degeneration and necrosis of some cells; in the portal area there were inflammatory cells, predominantly neutrophils, some lymphocytes, and eosinophils. Fluoroscopy revealed elevation of the right half of the diaphragm, which moved normally with breathing, and a further chest roentgenogram showed no change.

Because it was suspected that the patient might have an amebic liver abscess, chloroquin was started on a trial basis

Department of Medicine, Dalhousie University, and the Victoria General Hospital, Halifax, N.S.

– 250 mg. q.i.d. for two days, then b.i.d. The temperature became normal by day 5, when diiodohydroxyquin (Diodoquin; Searle) was started, 0.65 g. daily for 20 days. The patient was discharged on 24 October, afebrile and feeling well. Repeat liver scan in March 1969 indicated improved liver function but a continuing filling defect near the surface closest to the diaphragm. In February, 1972, now aged 76 and still working full-time, the patient was in excellent health and liver scan was normal.

Discussion

The difficulty in diagnosing amebic liver disease is well recognized; in a considerable percentage of cases in which investigation fails to detect *E. histolytica*, the diagnosis is established by the response to treatment instituted on the basis of clinical suspicion.[2] Lamont and Pooler,[3] in their study of 250 cases of hepatic amebiasis, reported that fever was an inconstant finding, that the serum alkaline phosphatase value was normal in 136 of the 189 cases in which it was determined, the serum bilirubin was >0.8 mg. per 100 ml. in only 19 of 187 cases, and roentgenologic findings were positive in 202 of 242: 168 had elevation of the diaphragm, and 33 of the others had supradiaphragmatic lesions such as patchy pneumonitis or pleural reaction. They suggested that a diagnosis of amebic hepatitis requires at least three of the following five criteria: 1) tenderness and enlargement of the liver; 2) response to specific anti-amebiasis therapy (emetine and chloroquin); 3) suggestive hematologic findings such as normochromic normocytic anemia and leukocytosis; 4) suggestive roentgenologic findings, such as elevation of the diaphragm, or patchy pneumonitis, pleural reaction, or linear atelectasis, at the right lung base; and 5) the demonstration of pus, either by aspiration or by rupture into an adjacent organ or serous cavity.

In the present case, *E histolytica* was not identified and there was no history suggestive of amebic infection. However, the liver was enlarged and liver scan revealed a filling defect, fluoroscopy showed elevation of the diaphragm (but normal movement), chest films revealed patchy pneumonitis at the right base and a right-sided pleural reaction, there was significant leukocytosis, and the response to anti-amebiasis therapy was dramatic. These criteria support a diagnosis of amebic liver abscess, which, presumably – in view of the patient's protracted and apparently healthy residence in Germany and then Nova Scotia – developed silently from an infection acquired previously. □

References

1. **Dickson, R. C. and Ross, M.:** Amoebiasis in veterans. *Canad. Med. Ass. J.* **61:** 13-18, 1949.
2. **Dorrough, R. L.:** Amebic liver abscess. *Southern Med. J.* **60:** 305-310, 1967.
3. **Lamont, N. M. and Pooler, N. R.:** Hepatic amoebiasis: a study of 250 cases. *Quart. J. Med.* **27:** 389-412, 1958.

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Qualifications for Entry of the Name of a Physician in the Provincial Medical Board Register of Specialists in Nova Scotia

At a meeting of the Provincial Medical Board of Nova Scotia, held on November 25, 1972, the Board by resolution, deleted the Section usually called "Group B" of the qualifications for entry of the name of a qualified medical practitioner in the Register or List of Specialists as maintained by the Provincial Medical Board.

The regulations now read:

"The following may qualify for entry of their names on the Register of Specialists, maintained by the Provincial Medical Board of Nova Scotia:-

Qualified Medical Practitioners who:-

(1) Hold the Fellowship or Certificate of the Royal College of Physicians and Surgeons of Canada; and

(2) Who have full registration for the practice of medicine with the Provincial Medical Board of Nova Scotia; and

(3) Reside in the Province of Nova Scotia."

Change in Requirements for Internship

At a meeting of the Provincial Medical Board of Nova Scotia held on November 25, 1972, the following resolutions regarding internships were approved, to become effective January 1, 1973:

I "that effective January 1, 1973, the minimum requirement for a Certificate of Internship for submission to the Medical Council of Canada to be one of the following:-

(a) a year of rotating internship

or

(b) a year of a training program in Family Medicine in which year the curriculum is equivalent to a rotation

or

(c) Certification in a Specialty by the Royal College of Physicians and Surgeons of Canada."

II "that the minimum requirement for granting a license for general or family practice be one year of appropriate general internship or an equivalent year in a family practice training program."

While these resolutions were recommended for adoption by Provincial Licensing Authorities to be effective July 1, 1974, the Board were of the opinion that in view of recent criticisms of the performance of graduates going into family medicine without sufficient hospital training in certain disciplines of family medicine, it was imperative to correct this situation as soon as possible, in order to maintain a high quality primary medical care.

It was realized that this had serious implications for members of the Class of 1973 of Dalhousie Faculty of Medicine. While the Board regrets having to take the action, the agreement to grant licenses to practice to 1973 graduates who have taken a straight internship has been rescinded and graduates who change their minds and elect to go into family practice, must conform to the new regulations and to obtain the equivalent of a rotating internship.

It also means that a certificate of satisfactory internship for the Medical Council of Canada examination will also have to meet the specifications as outlined.

The equivalent of a rotating internship may be acquired by a doctor who has completed a straight internship by making up the deficits in the requirements. Maximum credit would be given for the appropriate service completed; in other words, he would not have to complete a full year of rotating internship. □

A Skier's Lament

S. C. Robinson*, M.D., F.A.C.O.G.
Halifax, N.S.

As I write we are seeing the first major snowfall of the year – and it's almost spring. Of course there was lots of the white stuff last October, but all that did was disturb the sailing schedules. However, nature has a way of evening things up, and as I dislike gardening and all that that entails, maybe the snow will last 'till summer!

What has skiing got going for the doctor? Perhaps not much unless you happen to enjoy exercise, fresh air, magnificent scenery, good friendship and the excitement of developing the skill which changes snow from an obstacle to a fascinating conveyance. Could you enjoy a lunch break with goodies from the pack-sack and a pail of boiled tea after a couple of hours of gliding through the forest, or the special taste of beer from the can hidden in the snow near the top of the lift, sipped while you view the valley below? If so, skiing just might be for you.

*Professor, Department of Obstetrics and Gynecology, Dalhousie University.

How to get into skiing? Decide if it is to be cross-country or downhill. In the former, the skis perform the Scandinavian equivalent of the Canadian snow-shoe. You have support in the deep snow but also can learn to glide and progress in a smooth, graceful style. So long as there's snow and the bush is not too thick, you can travel nearly at will. Special trails are being developed in many areas, and of course summer hiking trails, old roads, etc. make excellent touring routes. Until very recently, several waxes were necessary for different temperatures and snow conditions. Recently all purpose no-wax bases have been produced and these promise to greatly simplify the sport. If you aren't planning to compete, take a look at those new skis. In many respects, cross-country skiing compares with hiking or cycling. It affords time to look at nature and one sees things which will be totally missed in the ordinary rush of life. The gear is fairly inexpensive, but you will be frustrated and disappointed if you don't invest in good quality skis, bindings and boots.

Who's for downhill? Most of the kids go for this and if you want to be where they think the action is, go downhill. Can you stand the pace? Forget it if you can't keep fit with a fairly regular exercise program – especially for legs, back and arms.

Be prepared to travel to developed ski areas (unless you live in Antigonish or Windsor where it's all on your doorstep and you can have 'a few runs' at noon hour). Some years this travelling will become quite a chore and require planning, trading weekends off, etc. Of course, you will soon decide to take a winter vacation in New England, the West, or Europe.

So here comes the crunch – downhill skiing is expensive. Only good equipment is safe. Club memberships, lift-tickets, and above all, travel cost plenty. However, if you're the type who enjoys this type of recreation, you probably don't care about leaving a taxable estate behind you!

Don't buy poor quality, cheap equipment, and remember your wife and the kids need equipment as good as yours. For the kids, good bindings and skis will serve several times as the children grow. If you are the type to plan, buy your gear in late winter, on sale, and you'll save plenty. It doesn't really matter if you ski with this year's equipment or last year's.

Be sure your boots and bindings are fitted by experts – they must be matched and installed correctly on the ski for proper balance and safety release. This is no 'do it yourself' job. Keep your bindings in working order with cleaning and lubrication. Proper summer storage is important. Talk to your instructor about this.

How to learn? TAKE LESSONS!

You'll learn downhill skiing faster, in safety and it's good fun in a group. The Doctor title disappears and your first name makes you feel like one of the human race again. Many of our colleagues have learned in a "ski-week" somewhere to be quite competent and to handle themselves with safety. You can soon learn to ski under control in most situations, but don't be disappointed that your teenagers very quickly surpass you. Above all, don't try to keep up with them!

One final tip. Offer to work weekends for your colleagues and try skiing through the week when there are no crowds. A few consecutive days of this and you're a new person – and better doctor.

Think snow!

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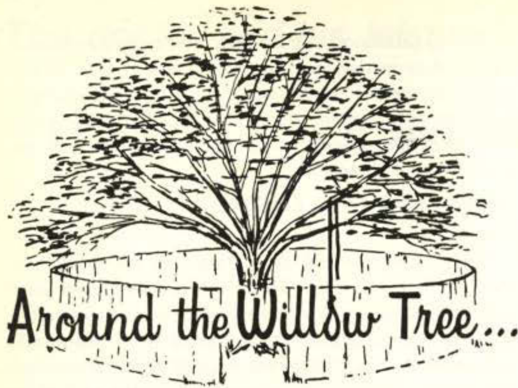


The Ams of The Ears

Recently, a 72 year-old white male presented himself in my office complaining of "a wonderful pain" in the chest. Needless to say, the gentlemen was a Newfoundlander, from Fortune Bay to be precise. I had heard the "wonderful pain" several times in the past and was cognizant of its meaning. However, hearing it again started me thinking about the unusual words patients sometimes use and also the possible derivations of these words. The use of the word "wonderful" to describe pain has much merit. Since wonder may mean fear, despair, dread, it is certainly reasonable to use wonderful to describe severe pain. When the man from Fortune Bay made his seemingly quaint, old worldly statement of having "a wonderful pain in the chest", he was telling me a great deal. As Osler put it: "Always listen to what the patient is saying. He is trying to tell you what's wrong with him."

My own first contact with a totally foreign colloquialism occured in Dominion, C.B., during my first few weeks in practice. I had examined a youngster and informed the mother that the boy had tonsillitis and that I was going to give him an injection of penicillin. She approved of this treatment but wasn't I first going to "lift the ams of the ears" like their old doctor always did? I thought my hearing had gone awry and asked her to repeat her request. She acquiesced and I heard the same sounds. Not knowing where "the ams of the ears" were located, I asked her to show me what the old doctor did when he wanted to perform this maneuver. The mother promptly placed her fingers under the angles of the mandibles and pushed up under the tonsils. I then placed my hands in the same position, much to the lady's delight, and thus the ams of the ears were lifted. The derivation of this phrase remains a total mystery. I queried my colleagues in the area at the time but not one could help. In any case, it worked. The patients with tonsillitis all recovered. Of course, the antibiotics made a secondary contribution. I came upon this phrase several times during the two years I worked in the Glace Bay area but not once in the twenty years I've been in Halifax.

On the other hand, there are many expressions common to both areas and others exclusive to particular places. And there are words whose origins are obvious but whose route to common usage mysteries. One of these latter is the word "glutch". When a patient complains that it is painful to glutch he means that it is difficult to swallow. Deglutition is the act of swallowing. Can deglutition and glutch have the same derivation? Or is it merely a coincidence that the words sound so much alike? In any case, many people use "glutch" who could not possibly have known the word deglutition.

A less mysterious expression is one which I completely misunderstood when I first heard it. A young lady, obviously agitated, had come into my office saying that she was "in a family way". I thought she said that she was in the family's way. I hastened to assure the sweet young thing that she couldn't possibly be in anyone's way and that I was sure her family loved her. This resulted in a further deluge of tears and promises that she would never do it again if I would get her an abortion. It was then that I realized what "in a family way" meant, and that she certainly was, and was to remain so until she delivered some seven months later.

A more esoteric presentation is the young man who presents with a yellow to greenish discharge from his penis, burning on urination and a recent history of sexual contact. This young man will say that he has "a strain" much more often than he has a dose of gonorrhea. The word "strain" probably derives from the effort exerted in the sexual act and before the gonococcus was discovered.

Another popular misconception is the one that appears when a patient is told that a bone is fractured. The reply that often comes forth, of course, is "Thank God it isn't broken".

And what depth of meaning, what pathos, what evocations of sympathetic understanding are elicited with the words "I'm losing my nature". What is one's "nature"? It is, of course, the ability to carry out one's sexual duties. The derivation could not be more obvious. It is natural for the male to have strong sexual urges and for the penis to become tumescent. I have never heard a woman complain of losing her nature, only of being "frigid". This is another example of male chauvinism having brainwashed the female into believing that the sexual desire is "natural" in the male but not in the female. This belief is rapidly disappearing and we can look forward to the day when young ladies will come in with the complaint that they, too, are losing their "nature".

Having "the bronichals" or complaining of a "gastric stomach" are relatively easy to understand. But what of the lady who cured her sore throat through a series of "meetings". This lady, in her early fifties, had had a sore throat for several days. Her home treatments having failed, she decided to try her family physician. As she later told me, she was about to open my door when she felt an invisible hand pressed against her chest. She took this as a message from the Lord, to go back home. She did this, called in her girlfriends and had a "meeting". This went on for nine days, twice daily, with interruptions only for the partaking of food and the necessary bodily functions. By

the end of this time the lady's ailment was completely cured. This is a type of therapy that has been practiced since man has been on this earth. It is inexpensive, has no undesirable side effects, is non-allergic and often is effective. It is a therapy that one should keep in mind. It might not help, but it won't hurt!

These are only a few examples from my own meagre experience. There must be many more expressions peculiar to other regions that would be of interest. The Bulletin would appreciate hearing from its readers on this subject. Perhaps someone even knows the derivation of the "ams of the ears". If you do, please don't keep it a secret. Lets hear from you. □

M.E.B.

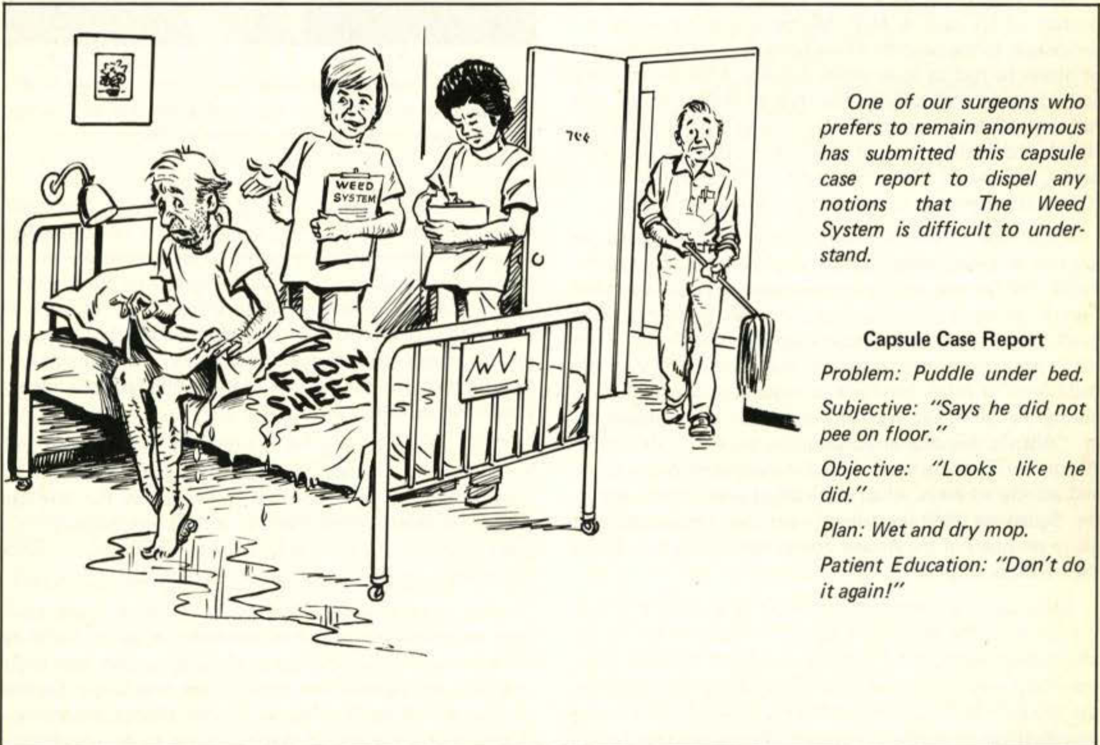
MEMBERSHIP DUES

Fiscal year 1973 is exactly half over. Of the 917 members of the Medical Society 190 have not yet paid their dues. The only source of revenue for the Society is membership contributions.

To whom it may concern – would you kindly give payment of your dues priority attention?

The Problem Oriented Medical Record

(WEED SYSTEM)



One of our surgeons who prefers to remain anonymous has submitted this capsule case report to dispel any notions that The Weed System is difficult to understand.

Capsule Case Report

Problem: Puddle under bed.

Subjective: "Says he did not pee on floor."

Objective: "Looks like he did."

Plan: Wet and dry mop.

Patient Education: "Don't do it again!"

An Appreciation

ALLAN REID MORTON

To write a suitable memoriam to Allan Reid Morton would take up an entire volume. Even then the story would not be complete, for who could know of the battles he fought within himself when confined to hospital as he was on several occasions when he had to suffer in silence political "action," when he had reluctantly to give up the active practice of medicine to devote himself to the prevention of disease. In Halifax he became the leader in promoting better health for its people and in controlling the epidemic diseases then so prevalent, especially during the wartime period.

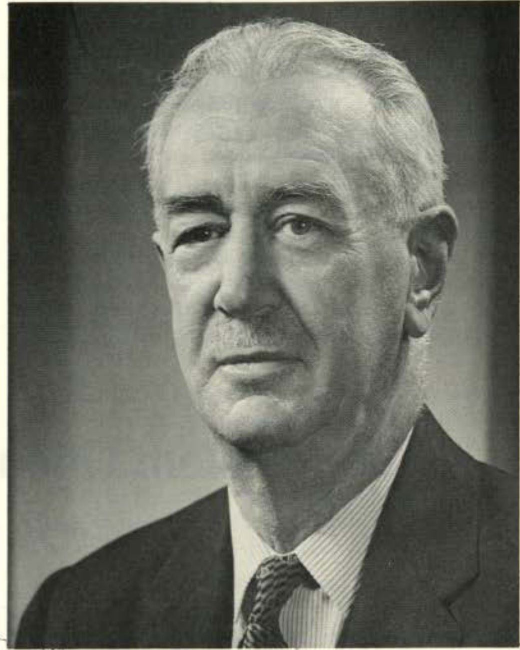
My remembrances of "Allan" go back nearly 40 years – during all this time my most vivid memory was his "friendliness". Allan seemd to like everyone and everyone liked Allan. Can more be said of a man who spent most of his life in public service?

Despite the occurrence of serious illnesses Allan was always cheerful, always the optomist, always planning for tomorrow and he carried others with him along this road – his wife, his associates and City Hall. It was under his leadership that Federal and Provincial Assistance was made available in the health field.

Allan grew up in the shadow of one of the most revered doctors of his day, A. McD. Morton and he never lost his dedication to the practice of medicine even when as a result of illness he had to leave active practice. After his recovery and post-graduate study he returned to Halifax as the first full-time Medical Health Officer – later Commissioner of Health and Welfare, and it was in this office he ended his career, retiring in 1963. The state of the public health in Halifax is a memorial to the dedication of Allan Morton.

His service in Halifax, though not in uniform during the last war was well recognized by the Naval, Military and Air Force. Halifax was the concentration point for all Canadian Forces going overseas – the health problems were monumental, including a major diphtheria epidemic – but these were overcome largely through the leadership and dedication of Allan. Halifax's record in the control of V.D. during that time was excellent, again due to the leadership of "Allan"; his Morality Squad with their "Orders to Report for Examination" were the scourge of Water Street and associated areas. Allan lost a lot of sleep accompanying the Squad on their nocturnal visits; his persistence kept many members of the Armed Forces out of Sick Bay during their Halifax stop-over.

Allan loved gardening, especially the growing of roses. His home on the Arm was a delight to the eye. Due to his efforts and those of his equally interested wife, his home was the showplace on the Arm. He delighted in giving away the products of his garden but always reserved a rose for his own buttonhole during the season. During some springs his



visits to the Provincial Buildings were made notable by his sorrowing over the loss of his rosebushes due to "winter kill"; at such times he even seemed to forget the calls of Public Health!

Trout fishing was another of his pleasures. The early Spring and the May fly rising could result in his leaving the office early and hastening to his favorite spots on one of the small lakes close to Halifax; "midging" for trout was to him a delight, especially when shared with other avid fishermen. Trips to Archibald's Lake near Sherbrooke were notable due to his enthusiasm. He loved to catch more fish than his host, the late Ed Kirk of Camp Hill fame; he wasn't always successful!

Despite his dedication to the public health he never lost his interest in medical practice. A regular attendant at Medical Society meetings and a teacher in the Medical School, students, both medical and nursing enjoyed his practical point of view and benefited from his freely given knowledge, especially that prevention was better than cure.

Allan loved to travel – especially by car. My wife and I were on such a trip with him and Helen across to the West Coast to California, Nevada etc. No one was ever such good company or showed more curiosity for new scenes. On the six-lane Los Angeles Freeway at five o'clock he demonstrated that a Haligonian was not going to be intimidated

by any number of Americans no matter how fast they drove; we finally got off the Freeway so I could go to the washroom.

Allan and his delightful wife Helen have been through many and varied experiences and have remained steadfast through illnesses, political upsets and changes in careers. Allan's passing will mean the end of a most successful partnership, but Helen will have many fond memories of that most loving, friendly, loyal and dedicated of men – Allan Morton.

We will not see his like again. □

J.S.R.

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NOTICE

We are looking for class pictures of Dalhousie Medical School for the following years: 1905: 1906: 1909: 1911: 1912: 1913: 1919: 1920: 1934: 1935: 1941: 1944: 1946. If you have one of these and would be kind enough to loan or donate it for publication in MeDal. Please send it to Miss B. Blauvelt, Deans Office, Sir Charles Tupper Medical Bldg., Dalhousie University, indicating that material is for publication in MeDal.

The annual scientific and business meeting of the Canadian Society for Allergy and Clinical Immunology will be held at Queen's University in Kingston, Ontario on June 15th. and 16th., 1973. Information may be obtained by writing the Canadian Society for Allergy and Clinical Immunology, 1390 Sherbrooke Street West, Montreal 109, Quebec.

The Consultant

Endowed with something special that the Lord
Bestowes, not evenly, across the board –
A pompous manner, frosted, haughty air,
Cold man of science, freezing sharply there,
A keen, no fooling kind of fellow too,
Who looses diagnostic hell on you!
Strange, how the sick desire for routine care,
A pleasant man, with sympathy to spare;
Some jolly, gentle fellow, like a friend,
To hear your troubles if you would unbend;
A round faced doctor with a cheery grin,
Round belly too with wholesome vittles in.
Though for consultant they'll have none of these
But long nosed, horse faced fellows if you please,
Who've never had a moment in their lives
To spend with friends or visit with their wives,
But gaunt and hungry stalk the library shelves,
Devouring authors emptier than themselves,
In whom a joyful noise produces pain,
Which only yields to current books again.
That's your consultant – cold, inhuman, chill –
A learned penguin, with a mammoth bill!

J. W. Reid, M.D.

The Doctors.

Stoddard King in Salt Lake Tribune

Nowadays there's little meaning
For a person to be gleaning
When a man attaches "doctor" to his name –
He may be a chiropractor
Or a painless tooth extractor –
He's entitled to the title just the same.

Or perhaps he is a preacher
Or a lecturer or teacher,
Or an expert who cures chickens of the pip;
He may keep a home for rummies,
Or massage fat people's tummies,
Or specialize in ailments of the hip.

Everybody is a "doctor",
From the backwoods herb concocter
To the man who takes the bunions from your toes,
From the frowning dietitian
To the snappy electrician
Who shocks you loose from all the body's woes.

So there's very little meaning
For a sufferer to be gleaning
When a man attaches "doctor" to his name.
He may pound you, he may starve you
He may cut your hair or carve you,
You have got to call him Doctor all the same.

Reprinted from The Nova Scotia Medical Bulletin, March 1927.

BMA/CMA

annual meeting

vancouver b.c.

june 14-21 1973

Group flight via AIR CANADA				
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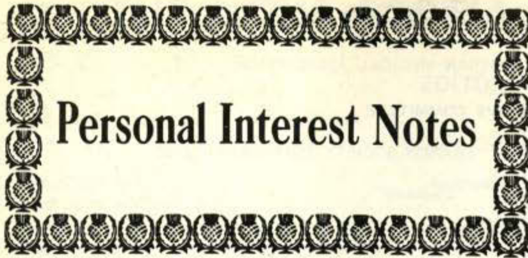

Home may be Halifax, but for 79 year old **Dr. Florence Murray** 48 years of heart and hard work have gone into Korea and even in her so-called retirement Korean students here can find understanding and familiar surroundings at her house.

A native of Pictou landing and a Dalhousie Medical School graduate, Dr. Murray headed for Korea in 1919 to open a missionary hospital in Manchuria. As chief medical officer, surgeon, administrator, laboratory technician and staff trainer she had her work cut out for her. But, it seems, it wasn't enough because when her 40-year missionary committment was up, she threw herself into another eight years as a volunteer worker in a Mission to Lepers. And following her return to Canada she trod the Manitoba lecture circuit, still visits senior citizen's homes and makes sure she is available to serve communion in church.

The Bulletin thanks Dr. Murray for her example of dedication and staying power.

* * * *

Congratulations are in order – if somewhat tardily – for **Dr. John Fraser Nicholson,** newly appointed Assistant Dean of Medicine at Dalhousie University.

A Dalhousie graduate himself and a native of Springhill, N.S., Dr. Nicholson was a general practitioner in Sherbrooke, N.S., from 1937 to 1938; completed postgraduate studies in London, England, and stayed in the United Kingdom for several months in a surgical practice. During World War II he served as a major in the R.C.A.M.C., then moved to a general practice in Glace Bay, N.S., and, after another move to the Grasslands Hospital, Valhalle, N.Y., became senior resident in psychiatry there.

He joined the Dalhousie University Medical Faculty as an Assistant Professor of Psychiatry in September, 1951; became a full time staff member in 1952; a Professor of Psychiatry in 1968; and in 1971 was acclaimed professor of the year by the Dalhousie Medical Students Society.

* * * *

The Atlantic Neurosciences Society held its Annual Meeting at the Victoria General Hospital, Halifax, Nova Scotia, on the 23rd and 24th February, 1973. Representatives from each of the Atlantic Provinces were present at the meeting. The Executive for the forthcoming year consists of the President, **Dr. J. Arditti,** Neurosurgeon, Saint John, New Brunswick; Vice-President, **Dr. L. J. deLima,** Neurosurgeon, Charlottetown, Prince Edward Island, and Secretary-Treasurer, **Dr. L. P. M. Heffernan,** Neurologist, Halifax, Nova Scotia.

* * * *

OBITUARIES

Dr. Allan Reid Morton (72) died February 1, 1973 at his home in Halifax. He graduated from Dalhousie University in 1925 with his MDCM. In 1939 he took a course in Public Health at John's Hopkins University, Baltimore and during this period he was the recipient of a Rockefeller Fellowship. He is survived by his wife, the former Helen Seymour Blackadar, three brothers and one sister. Our sincere sympathy to Mrs. Morton and the family.

Dr. John R. Macneil (71) of Glace Bay died January 30, 1973. He graduated from St. Francis Xavier University, then Dalhousie medical school and later took postgraduate work in the United Kingdom. He is survived by a son Dr. Arthur Macneil, Halifax, a daughter Delores (Mrs. Tim Daley) Dartmouth and three sisters. Our sympathy is extended to the family. □

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