

THE NOVA SCOTIA MEDICAL BULLETIN

EDITORIAL BOARD

Editor-In-Chief
Dr. J.F. O'Connor

Associate Editor
Dr. A.C. Irwin

Dr. A.J. Buhr
Dr. J.A.R. Tibbles
Dr. J.P. Welch
Dr. W. Putnam
Dr. T.J. Murray

Managing Editor
Mr. D.D. Peacocke

Editorial Assistant
Mrs. T. Clahane

The Physician, Organization and Management

The physician lives in a complicated society, made up of many organizations and groups competing for his or her time, attention or money. Usually many of these organizations have to be used by him for various purposes. How the physician interacts with these groups, ranging from government, Medical Society, licensing bodies, businesses and universities, right down to the local Scout troop, has become a complicated process over the years.

If one involves himself too much in the Boy Scout Troop or the local squash club, other groups get upset (your family and Revenue Canada!). But place too much time on patients and earning and your health and family may suffer. The art of life management is becoming ever more complex, and management itself in all its aspects has become a subject worthy of the physician's attention.

With the assumption of the title "Doctor", many lay people insist on presuming a basic competence in leadership and management that unfortunately is not present. Physicians then find themselves on Boards of Directors, advisors to government, president of the local service club, Parents/Teachers Association or head of a department in hospital, university or business. Inevitably he arrives at a position in life when he must manage, administer or lead either people and/or organizations. That is, he must perform tasks for which he has little training.

Strangely enough it is presumed that a physician manages his own practice of medicine, his own finances and investments, and his own career. In fact, doctors have proven very inadequate in many respects at all these management tasks. Even worse, physicians have failed to recognize that management theory is a real body of knowledge and that it is being used all around them, especially in the health care field. Functions such as planning, decision making, organizing, staffing, directing or actuating and controlling, are being performed by all of us in some way or another in our everyday lives, and these processes are worthy of thinking about.

A knowledge of management theory is an essential element in professional training and, in fact, physicians may be one of the last professions to discover the usefulness of this way of thinking. While not strictly a science, management does have theories and principles; intuition, experience and common sense however still play an important part in any management scheme. In fact, if intuition, experience and common sense are stressed, it sounds more and more like the practice of medicine. We have been using the phrase "patient management" for years and yet have shown little awareness that management itself has principles and is an organized way of thinking that we might apply, not only to the patient, but to the community, the practice itself, or even to the health care system. With the reality of a shrinking health care budget, we will start to see more and more adaptations of the management practices on business and industry. It makes good sense that we understand and use these practices to our own ends.

There is an existing and growing industry of management consultants, that it would benefit us to understand, if we are to play our proper role in health care. We may meet them in planning a new hospital addition, building a new clinic, or in trying to organize our practices more efficiently. Their jargon is sometimes a little "heavy", and some of their latest ideas and methods will not lead at all to good or efficient medicine. However, they often bring a factor to problems that we neglect; the step backward needed to see problems and solutions that are often missed. It would be beneficial to all if we could combine their ability with our knowledge of medicine, since our problems are often unique.

In this issue we see a mixture of articles that demonstrate this need for management skills among us. Since organizations are shaped by past practices, we see outlines of the history and function of some organizations that may help us to try and manage our environment. With that in mind we will publish more

of these articles in the future and give a stronger framework to the structure in which we must all practise. After all, good management would indicate that constant assessment is needed of any changes in our organizational environment to determine their impact. The changing manpower situation, the Canada Health Act, the changing fee schedule, all are good examples of this type of thing that applies to us all.

We are all managers in some sense of the word. Let me close with these thoughts, with a quote from the book, "*Enjoyment of Management*" by Frederick C. Dyer:

"One enhances his degree of satisfaction in being a manager by increasing his insight into people's motivations and understanding of the way organizations and groups operate beneath the surface. If you know what is going on you enjoy the game more." □

J.F.O'C

An Appreciation

DR. NARENDRA KUMAR SINHA

On May 1, 1985, Nova Scotia lost one of its most active Family Practitioners, with the unexpected and sudden passing away of Dr. Narendra Sinha, more affectionately known as "Naren" to his many friends and colleagues.

Born in Allahabad, India on October 12, 1943, Dr. Sinha obtained his B.Sc. from University of Allahabad in 1962, and his M.D. in 1967. He did his Surgical Residency in London, England in the Royal Hospital, Charing Cross Medical School, and St. Thomas Hospital, and was on staff at the Lewisham Hospital, London.

He came to Canada in 1974, and received Canadian Citizenship in 1978. He first started practising in Barrington, N.S., and was on staff at the Shelburne and Yarmouth Hospitals. He was appointed one of the few consulting civilian physicians at the Armed Forces Base in Barrington. With his move to Halifax, he received staff privileges at all the local hospitals, but was especially active at the Halifax Civic Hospital.

Dr. Sinha had a very illustrious career in business fields in Canada and Europe, and presented papers regularly at International Medical Conferences across

the globe. His positions held in the community included being on the Board of Directors, St. Mary's University, Halifax; and the Multicultural Association of Nova Scotia. He was also President of the South Shore Multicultural Council, Member of the N.S. Human Rights Commission 1976-78; Director of the Advisory Board of UNESCO 1976-78; Government of Canada Grantee 1977-79. He had a Regular TV Show on Multiculturalism.

He was a member of the College of Family Physicians of Canada; The American College of Chest Physicians; the Canadian Medical Association; Fellow of the American Geriatric Society; and a Rotary Club Member.

In his short life of 42 years, Dr. Sinha did what most people would have taken several lifetimes to do. He will be very much missed in the Medical scene in Nova Scotia. He is survived by his wife Gita, a Pediatrician; two daughters, Menka and Moneesha; a son, Minal; his Mother; a brother and several sisters. □

K.S. Cheah, M.D.,
Halifax, N.S.

Current and Future Issues — Nova Scotia Health Care System

J. E. Harris Miller, * M.D.,

Halifax, N.S.

Discussions on health care issues during the past five years have been dominated by the topic of *The Canada Health Act*.

This Act is a misnomer, in that it has little, if anything to do with the health of Canadians. In essence, it is a "money bill" which provided punitive measures to provinces who permitted direct patient charges.

For better or worse, the specific issues pertaining to *The Canada Health Act* have been laid to rest in Nova Scotia, and are, by and large, matters of historic significance.

There is a general mood in Canada to move away from the counterproductive discussions exemplified by *The Canada Health Act*, and commence a constructive dialogue on the major issues which will effect the health care system now and in the future. In this article, I will provide my personal opinion on some of these issues.

THE UNDERFUNDING ISSUE

It has been said that the health care system has an insatiable appetite to absorb money. Health care economists suggest that we have reached the point of diminishing returns for financial investment in health, and that future improvements in mortality and morbidity statistics will result primarily from lifestyle changes. This position is supported by many, in the ever increasing lobby for additional emphasis and funding for health promotion and disease prevention.

There is little question that such programs as anti-smoking campaigns, nutritional programs, seat belt legislation, and moderation in alcohol use, will enhance a healthy lifestyle. Some have gone so far as to state that, as an individual accepts more responsibility for his own health care, there will be a lowering of health care costs. The truth of the matter is, that the more successful these programs are in the long run, additional costs will be added to the system. This is predicated on the fact that as one lives longer, there is a disproportionate increase in the cost of their health care. This is not for a moment to suggest that health promotion and prevention should not be emphasized. It is imperative that such is the case. However, we should accept the programs for what they are — an attempt to improve the quality of life,

and not a panacea to control health care costs. We have long since passed the stage where substantial improvements in mortality and morbidity can be made relatively cheaply. I refer to the cost-benefit that programs in health sanitation, immunization, potable water supplies, nutrition and development of antibiotics, amongst others have had. As previously stated, economists note that we have reached the stage of diminishing returns, in that disproportionate and vast sums of money are required to have even a marginal effect on the conventional health status indicators.

Turning directly to the underfunding issue, the recent Canadian Medical Association Report *Health — A Need for Redirection*,¹ published under the Chairmanship of Joan Watson, concluded that:

"...the Task Force does not support the contention that there is underfunding generally in Canada."

Total ordinary government expenditure in health care in Nova Scotia was \$441M in the fiscal year 1980-81, and the estimate for 1984-85 is \$744M. This \$303M increase over the five fiscal years represents a 69% rise in expenditures with an average increase of almost 14%. In general, the Nova Scotia health system has fared better than most other provinces, and we have not had to freeze hospital budgets, nor impose "0%" salary increases, as has occurred in other jurisdictions.

During the same period referred to above, physician payments under M.S.I. increased from \$92M to \$153M, for a \$61M or a 66% increase, or an average of 13% per year. Obviously, the provincial treasury cannot continue to support such dramatic increases.

It should be noted that part of the cost spiral was due to the inflationary period. I remain firmly convinced that there is adequate funding provided to operate the health system. There are definite inefficiencies in the system and the correction of these would require social tradeoffs. Society and health professionals do not appear willing to accept the required changes. A good example of this has been the dismal record of provincial governments in their unsuccessful attempts to close inefficient small hospitals. From a community's standpoint, these hospitals provide a sense of security. They are also critically important to the economic life of a town, as they are often one, if not the major employer and the purchaser of goods and services. While it may be

*Deputy Minister of Health, Province of Nova Scotia, Halifax, Nova Scotia.

argued that these factors are irrelevant to health care planning, it is a fact of life which complicates the planning process.

I believe that two important factors placing additional financial pressure on the health system are public expectations and the demand for an ever increasing expansion of the number of services to be included in a government insured program. These include calls for a universal pharmacare program, insured hearing aids, eyeglasses, universal dental care, nursing home care, amongst other things. With such demands being made on the system, it seems relatively easy to accept the economists' statements on the ability of the health system to absorb an unlimited number of funds.

I will refer later in the paper to other matters pertaining to funding, but suffice it to say, that the funding issues relating to the cost of health care have always been a subject of debate, and I am convinced that such will always be the case.

MANPOWER

The Federal/Provincial Committee on Health Manpower was established to identify Canadian physician manpower requirements and suggest policy options which would allow the physician supply in Canada to balance as far as practical those requirements by the year 2000. The Committee recently completed their mandate and the report states that: "from 1961 to 1980 the physician supply (exclusive of interns/residents) increased 105% from 18,363 to 37,667 in Canada. The population increased only 30% over the same period, with the result that a physician population ratio increased from 1:1004 to 1:643.²

In general, those involved with the issue are in agreement with the general statement that the health system is headed for a drastic oversupply of physicians, unless corrective action is taken. The manpower report provides a number of recommendations, which range from limiting immigrant physicians, reducing enrollment in both undergraduate and post graduate medical programs, to general proposals that physicians establish only in areas which demonstrate a need for medical service.

The medical manpower issue is fraught with difficulties and there is a multiplicity of variables which must be considered. Some groups and individuals are content to become mired in an endless debate on the methodology and detailed statistics associated with manpower planning. We must, however, be cognizant of the fact that if a decision is made to reduce undergraduate enrollment, it will be five years before the effect is felt. This also serves to point out the necessity of a continuous revision and refinement of manpower data. The issues pertaining to medical manpower are both financial

and moral in nature. Graduates from medical schools are atypical in that they are the only group that I am aware of, who are guaranteed an income producing position following graduation. Any health system can absorb only so many physicians and it is incumbent upon us to ensure that Canada does not, in future, create a situation such as in Italy, where there are numerous unemployed physicians.

I believe that is immoral to subject an individual to five years of intensive study in medical school, with little or no hope of that person having an opportunity to obtain gainful employment. I realize that this is a contentious issue, and is countered by educators who are sometimes oblivious to the reality of the real world in putting forth their counter arguments based upon freedom of choice in matters of education.

Included in the above manpower issue, is the ever increasingly complex issue of Canadian graduates of Offshore Medical Schools. There is no doubt in my mind that at some stage, challenges under the new Charter of Rights will be issued for those denied interning positions.

There is an urgent need for government, medical schools, provincial medical societies, and medical boards to immediately commence discussion on the medical manpower question and attempt to reach a consensus on what action to take. Failure to do so might well lead to unilateral action by government, and if such does occur, it will be the result of collective inactivity and inability to provide government with policy options.

REGIONAL HOSPITALS

Over the years, Nova Scotia has developed an excellent system of small community hospitals. I refer to Canso, Sheet Harbour, Sherbrooke, Musquodoboit, Middle Musquodoboit, Lunenburg, Strait-Richmond, amongst others. While we have been fortunate in this development, the same cannot be said of our regional facilities.

One of my priorities as Deputy Minister of Health, has been the development of a comprehensive system of regional hospitals in Nova Scotia. Too many Nova Scotians have to travel to Halifax for specialty services, which could and should be available at regional facilities. This has served to place undue pressure on bed allocations in the teaching hospitals in the Halifax-Dartmouth area.

A prime example of this exists in Orthopedics, wherein 17 of the 18 Orthopedic surgeons in Nova Scotia are practising in the teaching hospitals in metropolitan Halifax. While there are a number of reasons for this concentration, the development of regional hospitals with appropriate modern facilities and support staff would facilitate a more rational distribution of specialists. This would also present many advantages to those in regional vicinities by

removing the necessity for travel to Halifax for procedures which would more appropriately be performed in their home setting. In most cases, I feel it is not practical to have a solo specialist, but that in most situations, two or more physicians in the specialty would be required at the regional facilities.

While progress has been made in some regional facilities, we are still faced with the need to construct a new Halifax Infirmary, St. Martha's, Grace Maternity, Cape Breton Regional and Regional Valley Health Services. This listing does not include other regional and community facilities which require major renovations.

The recent period of high inflation and fiscal restraint have delayed the Department's plans to proceed with the construction of regional hospitals, it nevertheless remains a top priority with the Department. The continuing emphasis on hospital construction is highlighted by the fact that according to Canadian Hospital Accounting Manual, the useful life of a hospital plant is estimated to be 25 years. And hence, the need to continue to apply a sound construction program for the hospitals of the province.

TECHNOLOGICAL DEVELOPMENTS

Tremendous advances have and continue to be made in all areas of medicine. Perhaps one of the most notable examples is in the area of diagnostic imaging, with the advent of C.A.T. Scanners and N.M.R.'s.

One topic on which most health care economists are in agreement, (a trait not commonly found amongst economists) is the laissez faire attitude of the users of health services to the ever increasing costs.

The general populace is not interested in cost benefit analysis or cost effectiveness studies with regard to various modes of treatment. Canadians, by and large, have adopted the attitude that when they are sick, they become 'instant millionaires' in their ability to consume health care services and financial considerations are of no direct personal interest to the individual. It then becomes the responsibility of government, hospital boards and medical staffs to attempt to provide some rational development to a system which is not cost sensitive and where the general populace demand immediate treatment of illness with the best available medical and technical assistance.

Not a great deal of attention has been paid in the past to cost benefits or cost effectiveness of new

technologies, but I believe the future will see an ever increasing demand by government for activity in this area.

TRANSPLANT SURGERY

This topic relates somewhat to the previous discussion on technological developments and raises the additional moral and ethical questions pertaining to transplant surgery. Transplant centres across the country appear to be proliferating and it is important that again a co-operative approach between government and the medical community be put in place in order to provide for an orderly development of transplant centres. It has been suggested, for example, that there is only need for three liver transplant units in Canada, while there are already many more hospitals that have embarked or are planning to embark on such a program.

I believe that the excellent reputation and service provided by the Kidney Transplant Unit at Victoria General Hospital could well serve as a model for inter-provincial planning for transplant centres in Canada.

The prime problem in organ transplantation programs is the continuing shortage of donor organs and all physicians should take an active interest in promoting organ donation.

HOME CARE

One of the major recommendations contained in the Nova Scotia Legislature's Select Committee on Health Report, is for the adoption of a province wide insured comprehensive home care program. There is a great deal of interest in this topic by those who cite the advantage of a shortened hospital stay, an expanded role for health professionals, and general improvements in the efficiency and cost effectiveness of the health care system. There is no question that home care has the potential to limit or reduce future growth in health care expenditures, but in the initial instance, home care would add a significant amount to the cost of the health care system. Given the current state of the economy, it is not unreasonable to expect that funding for such a program would have to come from existing programs, with the commensurate curtailing of present services. □

References

1. *Health — A Need for Redirection*, Ottawa: Canadian Medical Association, 1984.
2. *Federal Provincial Advisory Report on Health Manpower; Physician Manpower in Canada 1900-2000*, Ottawa, 1984.

"Hee is a better physician that keepes diseases off us, than hee that cures them being on us. Prevention is so much better than healing, because it saves the labour of being sick."

Thomas Adams (fl. 1612-1653)

The Visit of Abraham Flexner to Halifax Medical College*

T.J. Murray, ** M.D., F.R.C.P.(C), F.A.C.P.,

Halifax, N.S.

INTRODUCTION

Seventy-five years ago Abraham Flexner arrived in Halifax by train in the early hours of the morning and checked into the Halifax Hotel. A school teacher from Louisville, Kentucky, and a graduate of Johns Hopkins and Harvard, Flexner was now in the employ of the Carnegie Foundation. When he left on the afternoon train he had made some notes on the Halifax Medical College which would change its future dramatically. In fact, that brief visit resulted in the closure of the Halifax Medical College, the initiation of a new Faculty of Medicine at Dalhousie, and laid the foundation for important growth and development in medical education in Nova Scotia.¹

I will briefly review medical education in Nova Scotia and in North America prior to Flexner's visit to all American and Canadian medical schools, and then review the impact in Halifax of his report — Bulletin #4 of the Carnegie Foundation, known since as the Flexner Report.²

HALIFAX MEDICAL COLLEGE

Halifax Medical College began in 1868 as a three month summer session for Nova Scotia students who found it financially difficult to attend a full course of medical study at other universities.³ The students were expected to spend one or two years of study at the Halifax Medical College and then complete their training in Montreal, New York or England. To enter, high school matriculation was recommended but not required. Course credit was given in the form of a certificate of attendance to students who attended regular lectures in five courses. Instruction was by didactic lectures, and the provincial and city hospitals were used for bedside instruction.

Although it opened under the auspices of Dalhousie University, the new Medical School initially had no specific entrance requirements, and the curriculum was not graded or sequential. For instance, the requirement that students attend two courses of instruction in each subject might mean only that they sit through the same lecture by the same lecturer two years in a row. There were no laboratory facilities.

In 1875 the Halifax Medical College severed its affiliation with Dalhousie and in 1876 became affiliated with the short-lived University of Halifax.^{4,5} Cassie compared the state of medical education at Dalhousie at this time with the requirements for recognition by the Illinois State Board of Health in 1885 and found that it fulfilled virtually all of the requirements.⁶ There now was a pre-entrance requirement; the appropriate courses were taught; the length of courses was appropriate; attendance and evaluation procedures were acceptable; and dissections, clinics and hospital attendance were acceptable. The numbers of instructors also appeared to be appropriate, with eight professors, six lecturers, four instructors and two demonstrators, for a number of students that was much less than the number of faculty.

The situation was not nearly as good in most American medical schools. Even when the schools provided their own information, often exaggerated and unreliable, only half of the U.S. medical schools succeeded in this Illinois evaluation.

The University of Halifax failed after ten years because most of the Maritime colleges would not give up their sovereignty. During the ten-year association, only one medical student chose to be examined and receive his medical degree from this institution.

After the closure of the University of Halifax, the Halifax Medical College affiliated again with Dalhousie University in 1885, but in a rather loose fashion, with Dalhousie responsible for teaching chemistry, botany, zoology, and later physics, and all the medical subjects under the responsibility of the Halifax Medical College. The degree, however, was granted by Dalhousie University. This new affiliation brought with it new admission requirements so that all students must have high school matriculation or the equivalent before beginning medical studies.

Although later it would seem that all criticism leveled at Halifax Medical College came from the Flexner report, it is worth remembering that some criticisms were being addressed prior to that time.⁷ *The Montreal Medical Journal* was "beginning to criticize medical colleges in Canada in 1906 and 1907, and the *Canada Lancet*, commented in an editorial in January, 1908 that the *Montreal Medical Journal* "had some rather hard comments to pass upon the Medical College in Halifax".⁸ It goes on to say "now we have always thought that this college was doing

*Address to the Royal Nova Scotia Historical Society, December 7, 1984.

**Professor of Medicine, Head, Division of Neurology, Dalhousie University, Halifax, N.S.

Mailing address: Dr. T.J. Murray, Clinical Research Centre, 5849 University Ave., Halifax, N.S. B3H 4H7

good work, and we are still of this opinion. The students receive very good didactic teaching, and the clinical facilities are all that could be desired. Socrates taught a class of one and that class was Plato. The usefulness of a medical college is not to be measured by a building, the number of its teachers, the size of its classes, but by the quality of its teaching, both theoretical and practical. Some of the great medical schools are not found in the largest cities".⁸

Entrance requirements were becoming somewhat more strict. In the year that Flexner visited, the Medical Board of Nova Scotia noted that, at the August preliminary examinations for Medical School entrance, six of the seven applicants had failed.⁹ However, students could be exempt from examinations by having a high school or collegiate examination certificate, and more and more students were coming with this prerequisite. After all the qualifying procedures, twenty-four names were added to the student register for Medicine in that year, fourteen less than the previous year. The Board went on to note that for the degree of Doctor of Medicine, a total of 13 out of 18 candidates passed in all subjects. Of these, 12 were granted the Board's diploma, with one delayed because, although he passed all subjects, he was regarded as under-age to practise Medicine.

In 1909 Halifax Medical College was struggling along, providing what seemed to be a good solid medical education for practitioners to go into the community and take care of the people. It slowly improved the requirements for entrance, the teachers, curriculum and facilities. It attempted to receive from the University, meagre funds to improve equipment, and often the teachers had to forego their own salaries to provide funds to add space or add equipment. All in all the college felt it was doing a good job, slowly improving and producing a reasonable graduate.

THE STATE OF MEDICAL EDUCATION IN THE UNITED STATES

Medical education began in the United States with the formation of the Medical College of Philadelphia, later the University of Pennsylvania. The founders, Dr. John Morgan and Dr. William Shippea, envisaged an education which combined both the intellectual and the practical, and hoped to graduate a physician who was both a competent practitioner and an intellectual scientist trying advance knowledge about disease. Morgan wanted to see a good education prior to medicine, a graded or sequential course of studies, and teachers dedicated to teaching and research. Although he said "time will perfect what is properly begun", none of those things really occurred over the next 150 years of medical education, and it was the absence of those three principles in American medicine which was criticized by the Flexner Report.

The opening of the west, increasing population and migration from Europe all created a rapid demand

for physicians, faster than the new schools could meet. This led to the apprenticeship method of training. Even the developing medical schools of Kings College, Harvard and Dartmouth, begun in the 18th Century, were meant to supplement the apprenticeship program rather than replace it. Later medical schools began outside the universities, and the first of the profit-oriented proprietary schools began in Baltimore in 1807. Between 1807 and 1910, 457 medical schools were established in the United States and Canada, and the inevitable deterioration in medical standards occurred.

Proprietary schools were a lucrative business. To start one, a doctor need only advertise, and attract students. He might open his house for lectures, and had no requirement to have any laboratory facilities or other resources. It was said "wherever and whenever the roster of untitled practitioners rose to above half a dozen, a medical school was likely at any moment to be precipitated".¹⁰

Physicians were not held in very high respect, and it is not surprising, when we compare the training of various trades.¹¹ A barber took three years; a carpenter, printer or plumber at least four years; a machinist five years; and a pilot seven years. Doctors, however, could graduate after attendance at two lecture sessions of 15 weeks each, with no prior preparation for studies. Apparently it was felt that doctors needed only a practical training to take care of people, and that to produce a more complex and prolonged system of education would produce "a class of over-educated, supercilious, unpractical medical men, too good and fine for the average work of the physician".¹¹

A number of reports began to occur in the late 19th Century decrying the state of medical education in the United States. In 1877 Dr. William Pepper addressed the University of Pennsylvania and said it was hard to believe that places such as Mexico and South America, judged to be backward by American standards, had much more carefully controlled medical education than the United States.

THE MOVE FOR REFORM

The two principal medical organizations were the American Medical Association (AMA) and the Association of American Medical Colleges. The AMA wanted reform but had little impact. It was in the difficult position of wanting to encourage membership and representation from the medical colleges and its graduates, but wanting to reform them at the same time. For much of the 19th Century the meek and whining voice of the AMA was essentially unheard until it formed a Council on Medical Education in 1904. This was a group of outstanding men who began to evaluate the medical schools and rate them as A, B and C — A being worthy and C hopeless. Their reports were made public, and

resulted in the closure or merger of 29 schools in the four years prior to Flexner's Report.¹² The AMA still felt it was in a difficult political position to further reform medical school education, and enlisted the aid of the Carnegie Foundation to support a review.

In 1907 the AMA inspected medical schools and reported the dismal state of medical education. Immediately a number of schools went out of business because their state boards refused examination to their graduates, and it was evident that the 160 existing medical schools would probably be reduced to 100. By the time of the Flexner Report the number of schools had been reduced by almost 25%.¹³

Dr. Henry S. Pritchett, President of the Massachusetts Institute of Technology, was responsible for suggesting to Mr. Carnegie that a foundation be set up for the purpose of providing retirement allowances for professors and teachers, a suggestion that Mr. Carnegie adopted. It became clear they did not have the funds to grant pensions to everyone teaching in a college, so they first had to define exactly what a college was. They defined it as having certain entrance prerequisites; no religious restriction in its college charter; a faculty of at least six departments, each headed by a Chairman with a doctoral level degree; and an income producing endowment of \$200,000. Colleges then tried to pattern themselves on this definition, so that they could obtain pensions.

Pritchett was not satisfied, however, to advance teaching merely by making it more attractive and secure; he began to make the Foundation an objective and critical organ. His annual reports contained stern criticisms of academic standards and practices. Pritchett pressed the Board of the Carnegie Foundation on the need for reform in the professions, and wanted to start with the legal profession, but was rebuffed by the legal professional organization. When an unsolicited invitation to survey medical education came from the AMA, Pritchett immediately accepted.¹⁴

ENTER DR. FLEXNER

Dr. Abraham Flexner, a teacher in his own preparatory school in Louisville, closed his school and took a sabbatical in Heidelberg. He wrote his first book, *The American College*, a severe criticism of the elective system, and the lecture system that he observed as a student at Harvard. He had noticed that his students, whom he had prepared for college, frequently lost their enthusiasm for learning after getting there, and he felt that the colleges and universities were failing in their responsibilities. Although the book found limited readership, it did fall into the hands of Dr. Henry S. Pritchett.

On his return to America, Flexner thought he might find a "congenial occupation" at the Carnegie Foundation and obtained an introduction to Dr.

Pritchett.¹⁵ Dr. Pritchett allowed him to read a speech he had prepared and, on their next meeting, Dr. Pritchett asked Flexner if he would like to make a study of medical schools. Flexner assumed that he had mistaken him for his brother Simon who was a physician at the Rockefeller Institute. He called his attention to the fact that he was not a medical man, and had never set foot inside a medical school. Pritchett replied "that is precisely what I want. I think these professional schools should be studied not from the point of view of the practitioner but from the standpoint of the educator. I know your brother, so that I am not laboring under any confusion. This is a layman's job, not a job for a medical man."¹⁵

Flexner wrote in his biography "time and again it has been shown that an unfettered lay mind that is courageous, imaginative, and determined to master relationships, is in the very nature of things best suited to undertake a general survey. It was, for example, not a professional soldier, but rather a layman, Richard Burton Haldane — afterward Viscount Haldane — who re-organized the British Army and later the University of London." "The expert has his place, to be sure; but if I were asked to suggest the most promising way to study legal education, I should seek a layman, not a professor of law; or for the sound way to investigate teacher training, the last person I should think of employing would be a professor of education. Dr. Pritchett was right: even though I might well have been the wrong choice, the proper person to study medical education was a layman with general educational experience, not a professor in a medical school."¹⁵

Flexner may have been initially unsure of his ability to carry out the project but he jumped at the chance. In his autobiography he recalled an incident when Dr. Pritchett asked him to dine and talk about medical education.¹⁵ After dinner he offered him a cigar which Flexner accepted and smoked (his first and last). Weeks later, after he had started the work, he dined again with Dr. Pritchett who again offered him a cigar. "Thank you", he said, "I don't smoke". Pritchett said, "but you smoked a cigar when you dined with me before." "Oh, yes" he answered, "I would have smoked a cucumber that night."

Flexner was to be paid a small compensation, but to have an unlimited expense account. On December 1, 1908 he set to work on his survey of medical education in the United States and Canada. He commented "throughout, I struck from the shoulder, naming names and places. Pritchett stood behind me like a stone wall."

It is worth contemplating at this point the important place in this revolution in medical education of Dr. Pritchett. He had the idea, he led the move from reform, he selected the appropriate person, and he then backed that person to do what

needed to be done. Flexner did the job well, but Pritchett deserves an honored place in the history of medicine.

Flexner was accompanied on his survey of medical schools by Dr. M.P. Colwell from the American Medical Association. Dr. Colwell was a very painstaking and careful individual, but always had to be diplomatic because he could not offend the physicians and medical schools that the AMA represented.

In his autobiography Flexner stated "I had a tremendous advantage in the fact that I became thus intimately acquainted with a small but ideal medical school." The ideal medical school Flexner referred to was Johns Hopkins, founded in 1893 and under the direction of Welch, Halstead, Mall, Abel, Howell, and Osler." "Without this pattern in the back of my mind, I could have accomplished little. With it I began a swift tour of medical schools in the United States and Canada — 155 in number, every one of which I visited."

So what did he look for in the quality and value of a medical school?

1. The entrance requirements.
2. The size and training of the faculty.
3. The sum available from endowment and fees for the support of the institution and what became of it.
4. The quality and adequacy of the laboratories.
5. The relations between medical school and hospitals, including in particular freedom of access to beds and freedom in the medical school appointment of the hospital physicians and surgeons who automatically became clinical teachers.

He stated in his autobiography that "in half an hour or less I could sample the credentials of students filed in the Deans Office, ascertain the matriculation requirements and determine whether or not the standards, low or high, set forth in the school catalogue were being evaded or enforced. A few inquiries made clear whether the faculty was composed of local doctors, not already professors in some other local medical school, or the extent to which efforts had been made to obtain teachers properly trained elsewhere. A single question elicited the amount of the income of the medical school, and a slight operation in mental arithmetic showed the approximate amount available for the full-time teachers or for distribution as "dividends" among the practising physicians who were "professors". A stroll through the laboratories disclosed the presence or absence of apparatus, museum specimens, library, and students; and a whiff told the inside story regarding the manner in which anatomy was cultivated. Finally, the situation as respects clinical facilities was readily

clarified by a few questions, directed in succession — and separately — to the Dean of the school, the professors of medicine, surgery, and obstetrics, and the hospital superintendent — questions which were designed to ascertain the extent to which the school enjoyed rights or merely courtesies in the hospitals named in the school catalogue. In the course of a few hours a reliable estimate could be made respecting the possibilities of teaching modern medicine in almost any one of the 155 schools I visited in the United States and Canada."

Flexner and Colwell made their flying visits, visiting a different university each day. For example, part of his itinerary is as follows: November 6, Omaha, Nebraska; November 7, Kansas City; November 8, Lawrence, Kansas; November 9, St. Louis, Missouri; November 11, Oklahoma City; November 12, Norman, Oklahoma; November 14, Dallas, Texas; November 15, Little Rock, Arkansas; November 16, Memphis, Tennessee.¹⁵

There was much criticism of the shortness of the visit to each medical school. However, perhaps we might remember the remark of Dr. Abbott, Professor of Orthopedics in Portland, who responded, when the faculty there complained that Flexner took only one day in looking at the School, "That is where we were lucky!"¹⁵

"Elsewhere, dissection rooms are indeed found but the conditions in them defy description. The smell is intolerable; the cadavers now putrid, as at Temple University (Philadelphia), the Philadelphia College of Osteopathy, the Halifax Medical School, and in many of the southern schools, including Vanderbilt."

"Halifax Medical College requires attendance at a City Dispensary that possesses little equipment for treatment, still less for teaching; besides the College has no voice in its conduct."

"At Halifax, the fee income is some \$5,000 a year and the government makes an appropriation of \$1,200, - a total of \$6,200. The Faculty apportions this sum as follows: three-fourths of the fees are divided among the teachers; one-fourth of the fees, plus a government subsidy must carry all other expenses—heat, light, janitor service, laboratory maintenance: the disgraceful condition of the premises follows as a matter of course."

It is clear that Flexner was including Halifax Medical College among those American schools that were proprietary or profit-making institutions. "The conclusion, then, is irresistible that these schools, far from being the benevolent enterprises they are alleged to be, still "pay," both directly and indirectly; nor can a genuine altruistic motive be made out for any medical school which does not consistently devote its entire income to providing decent facilities and adequate instruction in the laboratories, or the

teachers, if competent, must rely wholly on their salaries. Clinical teachers ought undoubtedly to be paid, but not out of the fees at the expense of laboratories and laboratory men."

"Among endowed institutions that lend their name to proprietary medical schools, for which they cannot possibly control as long as they do nothing, are the University of Denver, Washburn College, Cotner University, Epworth, Baylor, Western, and Dalhousie University. Some of these institutions are very poor."

"Everywhere in Canada and in the United States wretched institutions refute criticism by pointing to their successful state board records. Halifax and Western University candidates pass in Canada side by side with students from McGill and Toronto, though not in an equal proportion; for even in the written examinations, better opportunities tell in the long run."

Flexner concludes that 250 more doctors per year should be trained in Canada, but said the task of supplying them should be at the moment safely left to the Universities of Toronto, Manitoba, McGill and to Laval at Quebec. "Halifax, Western and Laval at Montreal have no present function." Although he seems satisfied to wash his hands of the Halifax Medical College, he adds a thoughtful note: "At some future time doubtless, Dalhousie University at Halifax will need to create a medical department."

The Flexner Report recommended that medical schools:

1. Relate medical schools to universities, with the universities to develop adequate standards of teaching.
2. Create a scientific environment through in-depth teaching of basic medical sciences with accompanying laboratory exercises.
3. Select full time faculty members with a strong interest in research.
4. Arrange for students to participate in the care of patients in wards and dispensaries.
5. Emphasize the scientific approach to problems of clinical medicine.

VISIT OF THE CARNEGIE GROUP

Dr. Abraham Flexner and Dr. M.P. Colwell arrived by train in Halifax in the early hours of a Saturday morning in October 1909. They checked into the Halifax Hotel and the next morning called President Forrest and he, with Dr. Lindsay, Secretary of the Medical Faculty of Dalhousie, promptly called upon them at the hotel. Mr. Flexner asked his questions and then, planning to leave on an early train that afternoon, paid "flying visits" to Dalhousie University, the Halifax Medical College, the Victoria General Hospital and the Halifax Dispensary. The whole performance took four hours.

THE CARNEGIE REPORT ON THE HALIFAX MEDICAL COLLEGE

The Halifax Medical College was roundly criticized by the Flexner Report and was described, with Laval (Montreal), as being "feeble".² The University of Western Ontario was said to be "as bad as anything found in the United States"; Winnipeg and Kingston represented a distinct effort towards higher ideals; McGill and Toronto were excellent.

The Report criticized the fees going to the professors at The Halifax Medical College, and said the disposition of funds is reflected in the condition of the Medical College: "It possesses an ordinary ill-smelling dissecting room and a single utterly wretched laboratory for pathology, bacteriology and histology. There is no museum worthy of the name, and no laboratory work in physiology and pharmacology. The laboratory sciences have been starved that small dividends might be paid to generally prosperous practitioners."

The Report commented on the clinical teaching at the Victoria General Hospital and stated that "staff appointments are made by the government for its own reasons; the Medical College is forced to confer professorships on these appointees".

"Obstetrical opportunities barely suffice. The College has no dispensary and the students are required to attend the City Dispensary where the Medical School has no authority. The attendance was fair".

The Report criticized the association with Dalhousie, whereby the school did the teaching and Dalhousie Medical Faculty examined the students and gave them a degree.

Flexner asked "What is the value of the Dalhousie degree in Medicine, won by students whose opportunities have been provided by Halifax Medical College? The connection is, from the standpoint of Dalhousie University, highly objectionable." He goes on "there is a library and a small collection of specimens, not all labelled".

In the general text he criticized the advertisement of medical schools, indicating that they dishonestly overstated their resources in many instances. He used Halifax catalogues as an illustration of ones that abound in exaggeration, misstatement and half truths. He said that Deans occasionally know more about modern advertising than about modern medical teaching. The Halifax Medical College brochure stated "first class laboratory accommodation is provided for histology, bacteriology, and practical pathology". Flexner comments "one utterly wretched room is provided for all three". He stated that in many medical schools it is stretching terms to speak of laboratory teaching in connection with them at all, with Halifax among six medical schools used as bad examples.

THE RESPONSE AT HALIFAX MEDICAL COLLEGE

The staff of The Halifax Medical College was outraged. Dr. D.A. Campbell writing in the *Maritime Medical News*, July 1910, felt the report was unfair, biased and inadequate in its approach.¹⁶ He was disturbed that Flexner did not interview any Medical College teachers. In fact, Flexner stated years later that he invariably talked with teachers of medicine and the medical sciences and their students. He did none of these interviews at Dalhousie, meeting only the President and the Secretary of the University.

Campbell felt that the most serious charge was that it was a proprietary, mercenary, or commercial institution in its spirit and ideals. He felt all the other grave charges against the Halifax Medical College were easy to answer. His defence, however, merely corrected some minor inaccuracies about the examination process and the licensing body, and corrected some minor wording. He said that it was not 75% but 40% of the fees that went to the Faculty. He defended the library, stating that they were increasing books by the rate of \$200 per year.

Campbell complained that when the Report was completed, an initial draft was sent to the College and a committee attempted in vain to correct the errors. They tried to change the comment about the dissecting room to "there is an ordinary, well-lighted dissecting room" but the Report still came out saying that it was an "ordinary, ill-smelling dissecting room." In the criticism of the anatomy department, Campbell strongly objected to the fact that they suppressed and deliberately ignored the information that "every student is supplied, free of expense, with a set of bones for use at home". He was upset that this service was commented favorably upon in the discussion of Cornell. He concludes that this is an example of the fact that Flexner wished to destroy institutions such as Dalhousie, and that he was biased with fixed views before his visit.

Campbell was concerned about the criticism about fees going to the Faculty, and says that the report ignored the fact that Halifax teachers gave up their pay for two years so that the College could build a new wing, and provide the Pathology Laboratory and equipment.

Campbell notes that the Report stated "at some future time doubtless Dalhousie University will need to create a medical department", and says "yet the Foundation now absurdly asks that Dalhousie should destroy what she has in herself and in virtual affiliation with herself, before setting about building up a new school."

In a discussion of Campbell's paper, Dr. John Stewart agreed that the worst criticism was the comment "mercenary" for their founders and teachers,

and felt that the report called into question the good character of the Halifax degrees.

At the end of the Yarmouth meeting of the Medical Society of Nova Scotia where the paper was presented. The Society, having considered Dr. Campbell's criticism of the Report on the Carnegie Foundation on the standing of the Halifax Medical College, "finds that the Report is prejudiced, inaccurate and misleading. The Society considers that the best answer to the report is furnished by the good standing and success of the practitioners who receive their education in Halifax".¹⁷

"The Society believes that the Halifax Medical College has proved its efficiency and that it serves a useful purpose in the Maritime Provinces and Newfoundland, and it strongly recommends that every effort should be made to insure the continuance of a medical school in Halifax."

In the series of editorials in *The Canada Lancet*, the Carnegie Report was stated to have been unjust to the medical colleges of Canada.^{18,19} They state that "too much attention was paid to the buildings, chairs, tables, bottles, etc. and not enough to the quality of the teaching given by the staff to the students. The right sort of a teacher could teach a medical class under the shade of an old oak tree, and make good practitioners of them".

A.W.H. Lindsay, Registrar of the Provincial Medical Board, was also incensed by the Report, because it called into question the license provided by his Board, which depended upon the examination and degree from the Halifax Medical College and Dalhousie University. Since the Dalhousie degree was used to determine license, this calls into question the Board's license and he felt this could not go unchallenged. Despite his feeling that it should not go unchallenged, he made no statements or challenges to the criticism and made no attempt to refute the report.²⁰

Consternation is evident in the faculty minutes of the Halifax Medical College and the medical faculty of Dalhousie University. A special meeting of the Executive of the Medical College was held when the First Commissioner of Education for the State of New York wrote and said that he was considering rescinding the registration of the Halifax Medical College on the basis of the Flexner Report.

It is clear from the Carnegie Report and his autobiography that Flexner was relatively unconcerned about the possible minor injustices visited on any particular medical school as a result of his rapid survey and observations, as he was dedicated to the need to upgrade medical institutions. He felt that this could not be accomplished without the demise of the proprietary schools and the establishment of medical education within universities. There is evidence of a secret memorandum written by Flexner suggesting

Rockefeller millions be used to reduce the number of U.S. schools to 31, and he named those he felt should survive.^{12,13}

THE RESULTS

The Annual Report of the President of Dalhousie University for 1911-1912 contains this note regarding the formation of a new Dalhousie Medical School: "In the early part of the year 1911, Halifax Medical College, finding it difficult to carry on the work of medical teaching, approached the University with the request that it should undertake this task, and offered to sell its property to the University and assist the University in every way in obtaining an act of the legislature vesting in the University all the rights and privileges and teaching appliances hitherto held by the Halifax Medical College. After full consideration of the question the Board of Governors consented, and the transfer was made, though the Board realized fully that they were making a heavy financial sacrifice in doing so."¹

They state they were improving the laboratories, providing more equipment and providing a new laboratory for pathology and bacteriology. Although there seemed to be reluctance on the part of later medical school writers to acknowledge any relationship of these changes to the Flexner Report, it is interesting that in 1911, one year after the Report, the first full time qualified pathologist, Dr. M.A. Lindsay was appointed, and the Pathology facilities were move from their temporary quarters in the Nova Scotia Technical College on Spring Garden Road, to the present site on University Avenue. When Flexner met Frederick T. Gates, closely associated with John D. Rockefeller, they discussed over lunch where things should go from there. Gates said about the Flexner report "it is not only a criticism; it is also a program." He later outlined for Gates a plan for refurbishing a medical school which would require a minimum of \$1 million, and probably close to \$1.5 million. This involved buildings, new facilities and full-time faculty. He proposed initially that the sum of \$1.5 million be given to Johns Hopkins because they had done so much already, that they would do much more if they were endowed.

Rockefeller and Carnegie funds were donated to Dalhousie to build new facilities. The most important was the Public Health Clinic on University Avenue which provided space for outpatient care and teaching. Later Rockefeller funds would support the building of the Grace Maternity Hospital, and the Medical and Dental library.

Over the next few decades medical education in North America was altered remarkably. Virtually all medical schools went on to incorporate the principles outlined by Flexner, and for the next fifty years these principles formed a blueprint for medical education.

The adjective "flexnerian" has come to mean medical education with a strong basic science foundation.

The most striking changes following the Report occurred in the United States. There were no school closures as a result of this Report in Canada, but almost half of the schools closed in the United States. By 1922 there were 81 schools in operation. Only 70 of the 166 United States schools still persisted by 1962.

Writing in retirement, Flexner estimated that, between 1917 and 1928 alone, the combination of Rockefeller grants and institutional matching funds added \$600 million to the budgets of schools of medicine.

CONCLUSION

Flexner's Report merely brought to a head something that was known already about the sorry state of America's medical schools. His real impact derived from what occurred after the Report. Largely due to his efforts, John D. Rockefeller donated millions to improve the nation's medical schools through the general education board. Within a few years the University of Rochester was established, and major changes were financed at many medical schools, including Dalhousie. Others, who failed to obtain this philanthropic help, either closed their doors or recognized their own responsibility to upgrade their physician training.

It is clear that the Flexner Report, the highly publicized, and extremely important focal point for a major reform in medical education, was part of a reform movement that was gathering momentum. Hudson commented that Flexner was "not so much a revolutionary as catalytic to an already evolving process." It is also clear that Flexner took the concept of Johns Hopkins and used it as a yardstick in measuring all other medical schools. That major changes resulted is obvious, but it should not be forgotten, as Flexner himself recognized, that it was not the report that really made the changes, but rather, it was the large amounts of money poured into the improvement of medical schools afterwards that really made a difference. Thus Flexner should be remembered not so much for the fire he set but for the blueprint of the structure that was to rise from the ashes.¹³ It is fortunate that, despite severe criticism in the report, a Maritime medical school at Dalhousie was recognized as important, and worthy of substantial foundation support as one of the institutions in North America to be funded and developed.

Medicine is at a major crossroad today. The expectations of the public increase but restraint and cutbacks threaten medical services. We are used to a concept of development and expansion and have great difficulty ensuring excellence while reducing and downsizing the system. Universities have major

pressures and medical faculties are under the cloud of decreasing budgets, decreasing postgraduate training posts and threats of decreasing students. Many argue that we are overtraining physicians and specialists, while many areas of the country remain underserved. We have major ethical problems to solve. We have technical capabilities that may open doors to wonderful new advances in understanding but may, in fact, be destructive for mankind. Society on the one hand wants more humanitarian doctors, but on the other wants them highly trained in the latest advances in science and technology.

Perhaps we might pause at this moment and reflect — is it time for another Flexner? □

References

1. Murray TJ, Murray S. The History of Dalhousie Medical School Parts 1-4. *MeDal*. 1984-1985.
2. Flexner A. Medical Education in the United States and Canada. New York: Carnegie Foundation, 1910. Bulletin No. 4.
3. MacKenzie KA. The Dalhousie Medical School: An Historical Sketch 1863-1928. *NS Med Bull* 00: 1900; 50-72.
4. Bean RJ. Side Lights on Early Medical Teaching in Halifax. *Dalhousie Med J* Apr 1936; 1:5-9.
5. Bean RJ. Side Lights on Early Medical Teaching in Halifax. *Dalhousie Med J* Oct 1936; 1:5-9 (Part II).
6. Cassie JM. Medical Education and the Flexner Report: With Special Reference Medical Education at Dalhousie University. Master Thesis (1962).
7. Editorial (unsigned). *Maritime Medical News*. May 1909; 521:204-208.
8. Medical Colleges in Canada Unsigned editorial. *The Canada Lancet* 1908; 30:381-382.
9. Registrar's Report: Provincial Medical Board of Nova Scotia *Maritime Medical News*. 1909; 381-382.
10. History of Accreditation of Medical Education Programs. Condensed from "Historical Survey of Major Factors and Events that Have Influenced Medical Education". Document of the American Medical Assoc. *JAMA* 1983; 250:1502-1508.

11. Brieger GH. Fit to Study Medicine: Notes for a History of Premedical Education in America. *Bull Hist Med*. 1983; 57:1-20. (Page 5 refers to Veysey, giving reference Emergence, page 252).
12. New Light on the Flexner Report: Notes on the ANA-Carnegie Foundation Background. *Bull Hist Med*. 1977; 51:603-609.
13. Fox DM. Abraham Flexner's Unpublished Report: Foundations in Medical Education 1909-1928. *Bull Hist Med*. 1980; 54:475-496.
14. Hudson RP. Abraham Flexner in Prospective: American Medical Education 1865-1910. *Bull Hist Med*. 1972; 46:545-561.
15. Flexner A. Abraham Flexner: An Autobiography. Introduction by Allan Nevins. New York: Simon and Shuster, 1960.
16. Campbell DA. Medical Education in Nova Scotia. *Maritime Medical News*. July, 1910, 72:201-217.
17. Notes on the Yarmouth Society Meeting *Maritime Medical News*. 1910; 72:221.
18. The Carnegie Report on Medical Education. *The Canada Lancet*. Jan 1911; 44:337-338.
19. Medical Education in Ontario (Unsigned Editorial). *The Canada Lancet*. Feb 1911; 44:405-406.
20. Report on the Registrar of the Provincial Medical Board 1909-1910. *Maritime Medical News*. Aug 1910; 246-249. (Dr. AWH Lindsay).

MEDICAL PRACTICE PRODUCTIVITY

CONSULTANTS IN MEDICAL OFFICE MANAGEMENT

2737 Robie Street, Halifax, Nova Scotia B3K 4P1
454-6726

23 Cedar St., Stellarton (P.O. Box 437) B0K 1S0
755-5962

SPECIALIZING IN:

- policy and procedure manuals, customized to fit individual medical practices to ensure continuation of routine office procedures.
- temporary and permanent secretarial services
- overload typing
- filing systems
- office analysis
- conference planning
- customized appointment books

EFFICIENT OFFICE SYSTEMS ENSURES SATISFIED PATIENTS, STAFF, AND PHYSICIANS.

Lorne Elkin Rozovsky, Q.C.

In Practice with

KITZ MATHESON

BARRISTERS & SOLICITORS

P.O. Box 247, 5151 George Street, Suite 1600,
Halifax, Nova Scotia B3J 2N9
(902)429-5050 Infotex Telex 0604 3029-2001029 = KZM

The Provincial Medical Board of Nova Scotia

M. R. Macdonald,* M.D., F.R.C.P.(C),

Halifax, N.S.

The Provincial Medical Board of Nova Scotia as we know it today was incorporated under the Provisions of Chapter 172 *The Medical Act of Nova Scotia* in 1954 and is entrusted with the administration of the Medical Act.

At the present time, the Provincial Medical Board of Nova Scotia consists of fourteen (14) members, seven (7) of whom are appointed by the Government of Nova Scotia, six (6) by the Medical Society of Nova Scotia and one (1) by Dalhousie University.

The objectives of the Board are:

1. Setting and maintenance of standards for medical education;
2. Registration of physicians for medical practice in Nova Scotia; and
3. Discipline of members of the medical profession in Nova Scotia.

Although the present Provincial Medical Board was incorporated by Statute in 1954, legislation bearing upon medical education and licensure of qualified practitioners of medicine in Nova Scotia dates back to May 29, 1828 when the House of Assembly passed *An Act to Exclude Ignorant and Unskilled Persons from the Practice of Physic and Surgery*.

In 1856, *An Act to Regulate the Practice of Physic and Surgery* was passed, repealing the former legislation. This new Act provided for: (a) registration with the Provincial Secretary; (b) recovery of fees by registered persons; (c) physicians practicing in the Province before 1822 to be licensed without examination; (d) Provincial Medical Appointments to be held only by physicians duly registered; (e) certificates of registration to be received in evidence; and (f) a penalty of 5 pounds for failing to register.

The Act of 1856 prevailed until April 18, 1872 when *An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery* passed the Legislature. Under this Act the Provincial Medical Board was created, consisting of nine (9) members, five appointed by the Governor in Council and four (4) by the Medical Society of Nova Scotia. Provision was made for a Medical Register and its Annual Publication. Registration was compulsory and a penalty of \$20.00 a day was set for those who practised without registration.

The Medical Act was essentially unchanged until 1884 when it was amended, increasing the membership of the Board from nine (9) to thirteen (13) in the relation of seven (7) to six (6) appointed on the same basis as the original Board. Powers of the Board were increased as well as the Registration Fee.

The first meeting of the Provincial Medical Board was held in Province House, July 24, 1872. The first Medical Register was published in the Royal Gazette in August, 1873.

DUTIES AND RESPONSIBILITIES OF THE BOARD ARE SET OUT IN THE MEDICAL ACT Standards of Medical Education

"The Board may prescribe the qualification to be possessed by persons desiring to commence the study of medicine and prescribe the preliminary examinations to be taken or evidence of qualifications to be submitted by them before commencing that study".

At one time the Board held entrance examinations and also pre-registration examinations but, with the proliferation of medical schools and the complexity of medical education, this responsibility has been delegated to the Medical Schools and the Board accepts for Registration and Licensure graduates of medical schools recognized and approved by the Board. In relation to the North American Schools, this is really not a problem as these Schools are accredited by L.C.M.E. (Liaison Committee on Medical Education) in the U.S.A. and the C.A.C.M.S. (Committee on Accreditation of Canadian Medical Schools) but, for many of the Medical Schools outside North America, acceptance of their graduates for training and licensure constitutes a sizable problem.

The organized teaching of medicine has gone on in Halifax since 1868. It was first carried on by Dalhousie, then by the Halifax Medical College in affiliation with Dalhousie and since 1911 by Dalhousie. It has received continuous and strong academic support from the Provincial Medical Board. Mutual interests in creating and continuing high standards for professional qualifications have resulted in continuous and meaningful cooperation throughout the years.

Annual grants are given by the Board in support of the Continuing Medical Education program at Dalhousie as well as grants for the Dr. John Stewart

*Registrar/Secretary, The Provincial Medical Board of Nova Scotia, Suite 3050, Lord Nelson Hotel, 1515 South Park St., Halifax, N.S., B3J 2L2.

Memorial Lecture and the MacDougall Memorial Library.

Registration of Physicians

The pre-registration clinical requirements are always under active consideration and while generally speaking, in Nova Scotia a graduate of a LCME/CACMS Medical School requires a rotating internship in an approved program or a Certificate in a Specialty of the Royal College of Physicians and Surgeons of Canada, requirements for graduates of non-Canadian/U.S.A. Schools may vary considerably.

Discipline

The biggest change in responsibilities of licensing authorities in recent years has to be in the realm of discipline. Patients and relatives are complaining to licensing authorities much more frequently and, although most of the complaints are the result of poor or lack of meaningful communication between doctor and patient/relatives, yet many of the complaints are much more serious and probably should be directed to legal authorities rather than to the licensing authorities.

Problems with the misuse and abuse of drugs by the general population, particularly controlled drugs, is a cause for great concern especially when these drugs are obtained on doctors' prescriptions and many are diverted into the illicit street market.

The duties and responsibilities of the Provincial Medical Board may well increase in numbers and importance and more legislative authority may well be required in a revised or amended Medical Act to allow the Board to carry out many functions which will be required of it at some future date. □

JOINT INTERNATIONAL MEETING ON PAIN

THE CANADIAN PAIN SOCIETY /
THE INTRACTABLE PAIN SOCIETY
OF GREAT BRITAIN AND IRELAND

AUGUST 28-31, 1985
HALIFAX, NOVA SCOTIA, CANADA

TOPICS: Pain Mechanisms and Measurement
Pain in Children
Cancer, Low Back and Orofacial Pain
Workshops and Panel Discussions

Speakers will include:

U.K.: Profs. E. Wilkes, J. Thompson
Drs. S. Lipton, M. Mehta, M. Sluyter, J. Lloyd
Canada: Profs. R. Melzack, H. Mersky, B. Sessle,
B. Pomeranz, Dr. R. Tasker

Posters +/-Free Papers to be submitted before
June 15th, 1985

For details contact:

Mrs. Caroline Johnson
Department of Anaesthesia
Victoria General Hospital,
1278 Tower Road,
Halifax, Nova Scotia, Canada
B3H 2Y9

Phone Number: (902) 428-2325 or (902) 428-2328

*To my eyesight I'm accustomed
To my dentures I'm resigned
To my hearing I'm adjusted
But O God! I miss my mind.*



Professional Economic Consultants Ltd.

*Financial Planning and Practice
Management for Medical and
Dental Professionals across
Canada, since 1971.*

Suite 730, 5991 Spring Garden Rd.
Halifax, N.S. B3H 1Y7
(902) 423-1369

Doane Raymond

Chartered Accountants

Serving the Nova Scotia Medical community with a broad range of financial and management services including:

- tax planning
- practice management
- computerized accounting services
- computer consulting

12 offices in Nova Scotia — 35 offices coast to coast



HISMANAL*

astemizole Tablets/Suspension

The first once-a-day, non-sedating antihistamine

IT'S THE SEASON

Over 2.5 million Canadians suffer from the annoying symptoms of allergic rhinitis each year. For some, the simple sighting of a stray puppy or kitten can trigger a series of sneezes, runny nose and itchy eyes. But for most sufferers, the first early warning signs of spring like blossoming birch trees signals the beginning of the most distressing time of all... the Hay Fever season.

A period that also signals for the benefits of **HISMANAL**. The first once-a-day, non-sedating antihistamine.

PROVEN HIGHLY EFFECTIVE

With growing worldwide clinical documentation now involving over 2,400 patients, **HISMANAL** has demonstrated a positive response in up to 80% of the cases¹... a significant improvement to previously used antihistamine such as clemastine,² chlorpheniramine² and most recently, terfenadine.³

HISMANAL is equally effective in children and adults.²

80%

CONVENIENT ONCE-A-DAY THERAPY

Equally important, **HISMANAL** has demonstrated an exceptionally long duration of action.⁶ Thus **HISMANAL** provides a most convenient once-a-day dosage regimen, 24-hour patient protection and enhanced patient compliance.

1/DAY

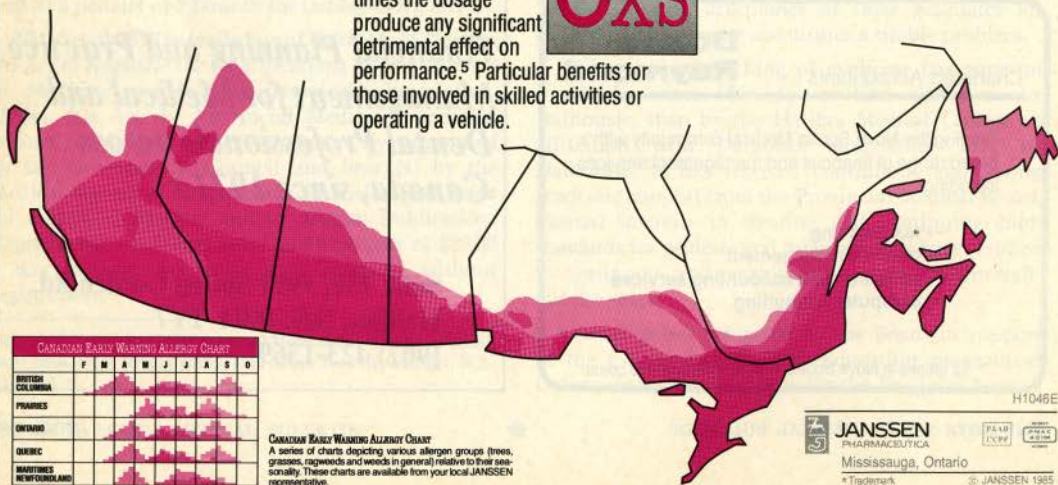
HISMANAL represents a major advance in allergy therapy for all age groups. The first once-a-day, non-sedating antihistamine that can provide significant improvement for hay fever sufferers.

PROVEN NON-SEDATING

Clinically, studies have also shown that **HISMANAL** even up to six times the recommended dose of 10 mg daily, did not cause detectable sedation,⁴ or at three times the dosage produce any significant detrimental effect on performance.⁵ Particular benefits for those involved in skilled activities or operating a vehicle.

6x's

"HISMANAL... a clinically significant improvement in antihistamines to date"⁷



CANADIAN EARLY WARNING ALLERGY CHART
A series of charts depicting various allergen groups (trees, grasses, ragweeds and weeds in general) relative to their seasonality. These charts are available from your local JANSSEN representative.

JANSSEN
PHARMACEUTICA
Mississauga, Ontario



H1046E

*Trademark © JANSSEN 1985

THERAPEUTIC CLASSIFICATIONHistamine H₁-antagonist

ACTION Astemizole is a potent, long-acting and selective histamine H₁-antagonist. It produces a dose-related inhibition of skin reactions to intradermal histamine. Astemizole inhibits the nose reaction to nasal challenge with histamine and allergens. It inhibits the bronchial reaction to inhaled histamine and allergens in asthmatic patients. Astemizole has extremely weak serotonin antagonism, no anticholinergic properties, no antagonism of dopamine or other catecholamines. Astemizole has no effect on the C.N.S. and does not interact with drugs acting on the C.N.S.

Astemizole is rapidly absorbed after oral administration. Peak plasma levels are obtained within one hour. Astemizole is extensively metabolized, and plasma levels of unchanged drug are low.

Astemizole is completely metabolized in the liver and mainly excreted through the faeces. Two metabolites of astemizole, desmethylastemizole and norastemizole have, orally, the same pharmacological properties as the parent compound.

INDICATIONS HISMANAL* astemizole is indicated for the treatment of seasonal allergic rhinitis, allergic conjunctivitis, chronic urticaria and other allergic conditions.

CONTRAINDICATIONS HISMANAL astemizole is contraindicated in patients with a known hypersensitivity to the drug.

PRECAUTIONS Use in Pregnancy Due to insufficient data, HISMANAL astemizole should be used in pregnant women only when, in the opinion of the physician, the potential benefits outweigh the possible hazards.

Use with C.N.S. Depressants HISMANAL astemizole had no potentiating effects with alcohol or other C.N.S. depressants in clinical and laboratory studies.

Drug interaction No drug interaction has been found between astemizole and bronchodilators, other systemic antihistamines, antibiotics, sulfonamides, corticosteroids, estrogens, progestogens, oral contraceptives, diuretics, antihypertensive agents, analgesics and anti-inflammatory agents, tranquilizers and antidepressants.

ADVERSE REACTIONS The incidence of adverse experiences during astemizole treatment was comparable to that during placebo control treatment.

During chronic treatment, body weight tended to increase. This is probably due to an increase in appetite.

Astemizole had no effect on laboratory parameters.

SYMPTOMS AND TREATMENT OF OVERDOSAGE In cases reported to date, involving oral ingestions of up to 300 mg of HISMANAL astemizole, no untoward effects have been noted.

DOSAGE AND ADMINISTRATION Adults and children older than 12 years of age: 1 tablet (10 mg) once a day. Children between 6 and 12 years of age: ½ tablet (5 mg) once a day.

Children under 6 years of age: 2 mg (1 mL suspension) per 10 kg/day.

To achieve optimal absorption, astemizole should be taken on an empty stomach.

AVAILABILITY

Tablets Each white, round scored compressed tablet contains 10 mg astemizole. Available in boxes containing 2 blister packs of 10 tablets each.

Suspension Each mL contains 2 mg astemizole. Available in bottles of 30 mL.

REFERENCES

1. Sussman, G. L.: *Today's Ther Trends* (in press) 1985.
2. Vandenberg, G. et al.: *A Review of Worldwide literature HISMANAL SYMPOSIUM*, Beerse, Belgium 1983.
3. Holgate, S. T.: *THORAX* 39 NO. 9 668-672 1984.
4. Smith, N. T.: *SATELLITE SYMPOSIUM, Am Acad All & Immun, Chicago, 1984*.
5. Seppälä, T.: *Curr Ther Res* 31: 638-44, 1982.
6. Laduron, P. M.: *Mol Pharmacol* 21: 294-300, 1982.
7. Knight, A.: *Cdn J Otol* 1985.

JANSSEN
PHARMACEUTICA



Mississauga, Ontario

*Trademark

© JANSSEN 1985

LEARNING DISABILITIES CONFERENCE

October 30 through November 1, 1985
Halifax, Nova Scotia

The Child Health Committee of The Medical Society of Nova Scotia is pleased to announce that the above Conference primarily directed toward doctors — November 1st being called "doctors' day" — is made possible through the joint efforts of the Atlantic Conference on Learning Disabilities, The Medical Society of Nova Scotia, and the Nova Scotia Government.

Guest speakers include Dr. Sylvia Richardson, President of the Orton Society of America and Dr. Crellen, Pediatrician and Chief of Child Clinic in Billings, Montana. Dr. Crellen is a learning disabled person. Other speakers will be announced.

Pertinent details relating to the Conference will appear in future publications.

Plan to spend a pleasant and informative weekend in Halifax, October 30 through November 1, 1985.

"E"

REALTY LTD.

Serving Nova Scotia

**OPPORTUNITY FOR CAREER
RE-ALIGNMENT**

Spacious well appointed home with inclusive Doctors Office, waiting-room, etc. This salt water view home is situated on an eight acre lot. Grant money has been available. **NOW** be your own boss with high net/income.

Price \$48,500

V. F. Clahane

PRESIDENT

Halifax, N.S.

Bus: 423-3002

Res: 477-5706

The Medical Society of Nova Scotia

D. D. Peacocke,*

Halifax, N.S.

The Medical Society of Nova Scotia was created in 1862 by the Province of Nova Scotia when its Constitution was approved.

The Medical Society is a voluntary association of physicians licensed to practise in this Province. All physicians so licensed are required by law to pay Medical Society dues or an equivalent amount if it is their choice NOT to join the Society, at this time all except two are Society members with the bulk of them being members of The Canadian Medical Association. In addition all Internes and Residents (344) and Medical Students (385) are members of the Society.

Council is the governing body of the Society with its actions subject to approval by all members of the Society at the Annual Meeting.

Council, about 160 strong, is comprised of members of the Executive Committee, Chairmen of Committees and Sections, Officers of Branch Societies, plus a wide range of various representatives and appointees to other bodies and organizations with which the Society has close association, affiliation, interest or relation.

The Medical Society's Executive Committee, more commonly referred to by many associations as a Board of Directors, is responsible for the ongoing operation of the Society between general meetings. It is comprised of 7 Officers elected annually, representatives from each of 15 Branch Societies and the Student/Interne/Resident block. The Officers act between meetings of the Executive Committee.

The Medical Society's official organ is *The Nova Scotia Medical Bulletin* established in 1922. The Bulletin, which features a high calibre of contributed medical articles and information, is published bi-monthly and mailed to all Nova Scotia physicians.

The Medical Society is closely allied with The Canadian Medical Association and is known as a Division of C.M.A. An important linkage is the C.M.A. Council arrangement. These Councils (Medical Education, Health Care, and Economics) are made up of appointees of the Divisions. The C.M.A. Board of Directors is composed of appointees from each of the Divisions.

The range of activities and interest of the Medical

Society is wide indeed, no doubt resulting from the broadness of the stated purposes. These include promotion of health and prevention of disease, improvement of medical services, maintenance of integrity and honour of the medical profession, and promotion of harmony and unity of purpose of the medical profession, and various other bodies having responsibilities for care of the sick and injured.

The Medical Society's Sections are important in this regard. Sections are structured specialist groups which serve as consulting bodies to the Society in relation to their own special interest and expertise. Almost all specialities are organized in this fashion. The Committees of the Society are numerous and they pretty well cover all problem areas of concern to the Society. Examples are: Child Health, Community Health, Cancer, Drug Abuse, Maternal and Perinatal Health, Medical Education, Physical Fitness, Membership Services, to name a few.

Membership in the Society opens the door to a wide range of services especially organized and designed for physicians. This applies particularly to the C.M.A. Seminars and courses in practice management, personal portfolio management, planning and designing facilities, use of computers in the medical practice, as well as telephone management and supervisory training courses for staff. A complete range of insurance programs and counselling services are also offered. Access to medical journals is also a benefit of value because of their place in the Society's C.M.E. policy.

C.M.E. programming is high on the Society's list of priorities. The Education Committee works closely with the Director of Continuing Medical Education at Dalhousie in identifying educational needs and designing suitable programs. Arising out of Committee activity, deficiencies or shortcoming in both under-graduate programs and C.M.E. programming are sometimes identified thus providing us the opportunity to upgrade the training.

Negotiations on behalf of members and member groups is a major activity of the Society. In this respect the Society is the official spokesman for regular fee-for-service physicians, Internes/Residents, and various specialty groups, usually in a salaried category.

The Medical Society has a proud heritage of service to both the public and the profession. □

*Executive Secretary, The Medical Society of Nova Scotia, Suite 305, 6080 Young St., Halifax, N.S. B3K 5L2

The Canadian Medical Association*

"What do all you people in here do?" doctors are frequently heard to ask, in bewildered tones, when they arrive at their professional association's Ottawa headquarters.

The blonde stone two-storey building, with its smoked glass windows, landscaped grounds and well-filled car park, is at least as imposing as an up-to-date medical centre in, say, Calgary. But everyone knows what the denizens of a medical centre do. Many of the activities housed in the Canadian Medical Association's (CMA) building on Alta Vista Drive may seem, to the uninitiated, much more mysterious. The Canadian Medical Association, "the national voice of organized medicine," was established in 1867 — the year Canada became a nation. Its first president, Sir Charles Tupper, was to become a Prime Minister of the fledgling country. Just as Canada is a federation of ten provinces, so the CMA consists of ten provincial divisions, autonomous within their respective provinces, which unite at the national level for the more effective handling of medical issues common to all.

The query about CMA activities is justified. It is also timely. The CMA's role, and the way the association fills that role, have evolved very rapidly over the last decade. It is 16 years since the CMA moved from Toronto to Ottawa to be closer to the Federal Government. During that period the association, and the whole profession, have watched the parts played by both federal and provincial governments in the provision of health care grow enormously. They have watched the erosion of physicians' income and self-confidence. They have seen an explosion of difficult questions — moral, ethical and professional — that practising physicians must face, and an avalanche of paperwork descend on them from the health bureaucrats.

In the years immediately after the move, the association was slow to develop the leadership role it fills today. It was too busy fighting a rearguard action on behalf of its members, responding to actions by government and other groups as they arose. Today, however, the buzzword around Alta Vista is "pro-active" and the mood is more aggressive. As the association's secretary-general, Mr. B. E. Freamo, explains: "We are no longer content to look at things after they have happened. We want to determine what are the sensitive areas, then spend our resources

developing policies for the future rather than fighting established policies. We are beginning to recognize that we must be intimately involved in the decision-making process, rather than reacting to other people's decisions."

The CMA has nearly 39,000 members — 80% of the country's medical manpower pool. Yet it is at a distance from its individual members — which is one reason for the widespread ignorance of its functions. Physicians are likely to be better acquainted with the provincial divisions, membership of which is obligatory in some provinces. Except in Quebec, it is the provincial medical associations that handle the most high-profile aspect of government-doctor relations: the fee negotiations.

Doctors can join the CMA only through their provincial associations, so the latter are the gatekeepers to the national organization. In most provinces, including Ontario, British Columbia and Saskatchewan, membership of the two associations is conjoint; a set amount of the dues payable to the provincial division is automatically remitted to Ottawa. In other provinces, physicians can belong to their provincial association without signing up for the CMA too; CMA dues are separate. Members who don't join the CMA often don't understand the need for a federal association working on behalf of physicians. The federal association, like the federal government, may seem rather remote.

Given this feeling, one might speculate that CMA membership would be lower if it was not so often part of a package deal with provincial association membership. However, CMA membership carries visible advantages. The first is the services of MD Management Ltd., the CMA wholly-owned subsidiary that offers physicians a valuable range of investment, financial planning and practice management services — from their days as interns until their retirement. The second is the *Canadian Medical Association Journal* (CMAJ), which is both an important scientific journal and a link between the different sections of the profession. Doctors can read about distinguished professional colleagues, new developments in health care delivery, activities in the provincial divisions, medical politics, practice management and investment. The *CMAJ* is the only place in which they can find this in one package — along with refereed scientific contributions. About one quarter of the approximately 100 people in CMA House work on the *Journal* which has a budget of over \$2 million a year and invariably attracts enough advertising to break even.

*Prepared by the Editors of the Canadian Medical Association Journal.

Mailing address: The Canadian Medical Association, 1867 Alta Vista Drive, Ottawa, Ontario K1G 3Y6.

Director of Publications, David Woods, the seasoned journalist who is in charge of both the *CMAJ* and the second journal published out of CMA House, the *Canadian Journal of Surgery*, expects the *CMAJ* to make a significant profit this year, and a larger one next year. But such expectations are based on the *Journal* retaining its hard-won second class mailing privileges, he points out; "Without those, we could be in the red." If that were to happen, physicians may find that they could no longer receive their 24 issues of an international journal of excellence without paying for it.

So while MD Management Ltd. and *CMAJ* are the upfront incentives to membership, they don't entirely bridge the gap between physicians and the national organization. This gap is a concern of the secretary general. Woody Freamo (the "B.E." is rarely heard around CMA House) agrees that "it is hard for a youngster at the start of his career to see what we do. And if we explain ourselves in terms of the *Journal* and the financial benefits of MD Management, because these are the tangible advantages to joining, we are further obscuring our other, equally important, but less immediately visible, functions."

Woody Freamo became secretary general of the Canadian Medical Association in 1982. An Ontario native, who studied economics at the University of Toronto and served as a RCAF bomber navigator in the war, he is the first non-physician to become the association's chief officer. But he is a CMA old-timer; he joined the organization more than 30 years ago, has guided its developments from behind the scenes for more years than he cares to remember, and he knows the main characters and issues in Canadian medicine. He also knows that the association should never be more than a sum of its constituent parts: "We are here to represent the viewpoint of the medical profession on a national basis, to both government and the public", he explains.

That viewpoint is developed and articulated through the work of three councils, which together are the backbone of the association. Physicians from each provincial division sit on the councils, bringing with them the views of the doctors in their home provinces.

The *Council on Medical Education* keeps an eye on the education, training and maintenance of professional competence of doctors. One issue it has recently considered is the training of primary care physicians. A task force, headed by Dr. Larry Wilson of Queen's University, spent many months looking at the current levels of education for family practitioners and examining methods of improving on these. The report of the task force was well-received and is now undergoing close scrutiny by all concerned. Another concern is the number of Canadian citizens who are receiving a medical

education abroad, with the intention of returning to practise in Canada. A third concern is continuing education for physicians: the council is looking at different educational methods that allow doctors to keep up with developments in their field.

Mr. Joe Chouinard, the Council's coordinator for the last 8 years, comments, "So many of the council's activities are behind-the-scenes stuff that they aren't obviously beneficial. But if the council didn't exist, the practising physicians would have little input into medical education. That would be a damaging loss."

In addition to maintaining standards of medical training in this country, the Council on Medical Education has an important additional objective: providing the right number and mix of doctors to answer Canada's health needs. Medical manpower planning has been a contentious issue for years in Canada: the profession has been reluctant to allow government to collect statistics on practice patterns, fearing what use might be made of them. Recently, the CMA swung into action on its own data bank, which will be strictly controlled by the CMA Board of Directors. Explains Freamo: "The fine-tuning of the system needs input, and the only people the doctors will trust is their professional association. We know that Statistics Canada and the Department of National Health and Welfare are waiting with bated breath for our figures — but there will be a lot of discussion before we release anything."

The association also established a special Manpower Committee chaired by president-elect, Dr. William Vail, to study the problem of physician supply. It is hoped that answers to such questions as "do we have too many/not enough doctors in Canada?" can be answered by the committee once all the data have been collected, studied and digested. It is an undertaking which the Board and the Executive of the association regard as a top priority. It appears particularly unlikely that the CMA will seek to make any commercial use of the lists of doctors — although a similar data bank under the auspices of the American Medical Association yields \$4 million a year in leases to carefully-selected direct mail merchandising houses.

The second of the councils that develops CMA policies is the *Council on Health Care*, the coordinator of which for the last 13 years has been Dr. Normand Da Sylva. This council has a very broad mandate: "the provision of comprehensive health care in the protection of the individual, the family and the community". This includes such thorny subjects as abortion, drugs (what should be available and to whom), accident prevention, pollution, sex education in the schools, and alcohol advertising. Often this council is in the uncomfortable position of having to react to an issue that has already become a hot topic in the media: the latest example is the question of the government's legalizing the use of heroin for

terminally-ill patients. This is the kind of question where a shift to the pro-active role is important. "We need to formulate policies before administrative decisions are made by governments that we might have to fight", comments Freamo.

It is probably the work of this council, in its role as patient advocate, that practising physicians know best. Its endorsement of the need for seat belt legislation helped speed the passage of the necessary laws in provincial legislatures. It was responsible for the *Guide for Physicians in Determining Fitness to Drive a Motor Vehicle*. It has drawn up and publicized guidelines on when physicians may consider issuing "no resuscitation" instructions. And it has issued significant policy statements on environmental health.

The third council deals with the bottom line. Mr. Orvill Adams, a health economist, became coordinator of the *Council on Economics* four years ago. The council's job is to collect, collate, interpret and disseminate information on the costs of health services and act as a source of information on medical economics for the provincial divisions. "Our focus is the overall economic environment within which Canadian physicians function", explains Adams. Although the CMA itself does not play any direct part in fee negotiations, this council provides a forum at which provincial representatives who are involved in fee negotiations can discuss policies and tactics. Each year the council hosts a negotiating conference. An outside team of instructors who are professional negotiators is brought in for a workshop on communication skills that can affect the outcome of bargaining sessions. Doctors learn not only how to present their arguments but also some of the message conveyed by body language.

The council has also looked at such issues as alternative methods of payment for services, alternative mechanisms for dispute resolution, and cost-effectiveness of nurse practitioners and physician assistants. But the focus is much wider than physician incomes. Any discussion of underfunding in sectors of the health care field soon highlights the shortage of funds for all health care services, especially in our hospitals.

The councils are the bodies that shape policies, but for informative discussion they need facts, facts, facts. These are collected and analyzed by a specialized unit that also comes under the direction of Orvill Adams; the *Statistics, Systems and Economic Research Unit*. This unit provides the factual ammunition that the CMA needs for submissions to government — both to specialized commissions, such as Justice Emmett Hall's 1979-80 inquiry into the state of medicare across Canada, and to committees of parliamentarians such as the 1981 Parliamentary Task Force on Federal-Provincial Fiscal Arrangements.

The troika of councils is the only national arena where all members of the profession — specialists, generalists, administrators and academics — can discuss issues of national concern. Most of these issues will be raised at the CMA's annual general meeting when members can suggest topics for further investigations, discuss the results of such investigations, and vote on CMA policy. The councils are effective both within the profession, as marketplaces for information, and in the public interest, as pressure groups for seat belt legislation, for example, or for improved drug labelling.

Although physicians are the primary decision-makers in medical care, they are members of a team that also includes a number of specialist technicians. The CMA's *Committee on Allied Health*, which reports directly to the Board of Directors, keeps an eye on the educational programs for several important health technologies. The committee's coordinator, Mrs. Alexandra Harrison, is responsible not only for the accreditation surveys of various training centres across Canada, but also for the addition of several health occupations to the list of groups the committee evaluates. Programs in medical laboratory technology, cytotechnology, respiratory technology, nuclear medicine technology and medical radiation technology have been accredited for some time. Recently, the committee, in cooperation with other organizations began accreditation of programs for ambulance attendants, ultrasound technologists and ophthalmic technicians. In the works is a massive document, *Perspectives on Health Occupations*, which defines all allied health occupations from the point of view of both the occupation in question as well as the medical profession.

The role of coordinator and communication channel between the 10 provincial divisions is one that the CMA has always played. But new demands on the CMA have required it to expand its leadership role in the political arena. Although this was the main reason for the 1969 move to Ottawa, the CMA was slow to embark on the tortuous process of making contacts with government, specific ministers and public servants. "At that time," explains Mr. Doug Geekie, director of communications at CMA House, "there was no concept of a political action program. Five or ten years ago, from a political point-of-view, the CMA was a non-starter. Politics were considered slightly 'dirty' around here. If we were invited to appear before a parliamentary committee, we would present a well-researched brief and then quietly leave, assuming our opinions would be given serious consideration. Now we've learned that if you're going to have some impact, you must make a political, as well as a factual, presentation. You've got to learn how to make politicians listen and how to make things happen."

Doug Geekie is another CMA old-timer; he has been with the association for more than 18 years. Throughout his time there he has been in charge of media relations. Ten years ago, that involved fielding about a dozen calls a week. Today the figure is closer to 60. Despite the increase, callers are still put straight through to Geekie who is on first-name terms with most of the medical journalists in this country. Queries are answered with genial patience; most callers are referred to experts. Geekie considers that opening up the profession to the press has been one of the CMA's successes: "The public today is more concerned and knowledgeable about health care. The media reflect that, and we have to be prepared to meet their concern."

Today, opening up the profession to the press is only part of Geekie's job. The other half is building bridges into government. Geekie is secretary of the political action committee and principal senior staff person responsible for links with government and party organizations. He attends the annual conventions of all three federal political parties, maintains information files on all 282 MPs, runs the MD-MP contact program, monitors federal legislation, attends hearings of House of Commons committees, such as the health, welfare and social affairs committee. He regularly meets with MPs and bureaucrats.

In Geekie's office hangs a plaque that reads: "The person who says he is above politics is really saying that democracy is beneath him." Geekie has made this his credo in the last 5 years. CMA briefs to committees are now well-orchestrated "events". At the 1981 hearings of the Task Force on Federal-Provincial Fiscal Arrangements, for instance, the CMA case was presented with audio-visual techniques, and not only by CMA officers but also by doctors from the ridings of MPs who sat on the committee, and Geekie made sure that reporters from their local papers were on hand to hear the doctors' descriptions of how underfunding had affected local medical facilities.

Doug Geekie was also one of the few people who attended every single hearing of the 1980 commission of inquiry conducted by Justice Emmett Hall into the state of Canada's health insurance program. Thank to his assiduous attendance, the CMA had a pretty good idea of what Justice Hall was going to recommend. When Hall's report, *A Commitment for Renewal*, finally appeared, the CMA was ready with its response and counter-arguments.

How far is the profession aware of this side of the CMA's activity: the protection of the profession's interests within the legislative sphere? "Doctors who are involved in their associations are well-informed",

comments Geekie. "But the bulk of physicians across the country know too little. There is no reason why they should know all of the details regarding what's going on, but they should be better informed. And the unfortunate aspect of successful political action is that you often have to keep quiet about it because if you mouth off you may destroy your victories. The failures are all too evident."

To a family doctor 3,000 - 4,000 km. from Ottawa, the Canadian Medical Association may seem a remote, unwieldy machine with little relevance to his or her practice. Some of the association's more controversial policies, such as the positions on abortion or extra-billing, may clash with a practitioner's own views. In those provinces where membership is neither obligatory nor conjoint with membership of the provincial division, that extra \$135 can look like an unnecessary expense. And some people are non-joiners by nature: membership of their professional association is as unappealing as membership of a political party, stamp-collecting club or golf club.

But without the CMA, the individual physician would be a great deal more vulnerable vis-à-vis government or the public. Doctors would have no way of registering approval or dislike of policies that affect them, no way of intruding informed medical opinion into national debates on health-related issues. Changes to legislation under the Canada Health Act calling for arbitration in the case of fee disputes has shown how effective CMA lobbying can be. At the national level, lobbying is more important today than it has ever been before — and the number of groups with representatives in Ottawa has tripled in the last decade for that reason. Small businesses, oil companies, consumers, the handicapped, all the professions, multinational conglomerates, native peoples, children, are all struggling to make themselves heard in Ottawa, through either staff lobbyists or consultants on contacts. Doctors cannot afford to be left out of the process. Which is why, the denizens of CMA argue, \$135 a year represents pretty good value.

For most doctors, fees to their professional association cost only about 0.5% of their gross earnings. Members of Canada's largest labour unions pay at least twice that percentage of their incomes, and any Canadian businessman would be happy if he could protect his business interests in the political arena for 0.5% of his gross income. Annual dues to the head offices of other professional associations start at \$200 and climb sharply from there. Given the range of issues that involve physicians, and the fringe benefits that CMA membership entails, physicians may be said to get a lot of mileage out of CMA membership. □

Retiring President's Address*

The Medical Council of Canada

Gordon S. Cameron,** M.D.,

Hamilton, Ontario.

Mr. President, fellow members and distinguished guests — I include in that address mes chers amis de la langue anglaise et aussi my equally dear friends whose mother tongue is French—we who hold the licentiate of the Medical Council of Canada, and who are permitted by a provincial medical licensing authority to practise medicine, enjoy a rare privilege. On a daily basis, we have an opportunity of applying our knowledge and skills to have some influence for either a little bit of good or a little bit of harm to each patient with whom we come into contact. Our hope is that it will be an influence, a little nudge, in the direction of assisting him or her in pursuing that goal of reaching his or her fullest potential.

When we approach patients, at a distance they all appear the same, but we know that on closer examination, and as we gain more knowledge of them, we cannot help but marvel at how unique each individual is. Each person has his or her own strengths and weaknesses, and we soon come to realize how important are the relationships of that person with those closest to him or her, including those who are trying to help him or her.

Each organization of people is just such a living organism, with its own strengths and weaknesses, with its own special purpose, its unique composition, and certainly its interdependence with other related organizations.

It is from that perspective that I would ask you to consider the Medical Council of Canada. Our special purpose is clear. It is enshrined in legislation and in Letters Patent. Our first objective is to establish and promote a qualification in medicine, known as the Licentiate of the Medical Council of Canada, such that the holders thereof are acceptable to provincial medical councils for the issuance of a licence to practise medicine.

We can be justifiably proud that, through the continuing dedication of this Council and its servants, the diligence of our Examination Board, and the expertise of the R.S. McLaughlin Examination and Research Centre, this qualification is recognized

worldwide as a gold standard. This may well explain the phenomenon that has caused, perhaps inappropriately, great concern to Council, and that is the continuing demand by thousands of physicians throughout the world to meet the challenge of our Evaluating Examination, despite the strongest advice that opportunities for immigration to and practice in Canada are severely limited.

But neither can we be complacent, if we are to maintain and further enhance the high reputation that our qualification enjoys. Council must continue, to use the words of that wise sage, Jack Noakes, "to be vigilant in all matters related to the award of its qualification".

If there is a characteristic that has been increasingly evident in the mood of the Medical Council during the years I have been privileged to serve as a member, it is a recognition that vigilance cannot be equated with reaction and complacency. Vigilance implies a continuing responsibility to struggle to ever more clearly define the characteristics essential to clinical competence, and to develop ever more effective methods for their assessment.

Sam Kling expressed this most clearly and succinctly, and much better than I can, in his address to Council last year. When Council confers the licentiate on candidates, it is, in effect, saying that, in its opinion, the candidate has demonstrated that he or she possesses the minimum level of required knowledge, psychomotor skills and behavioural attributes required to practise medicine, and it is, therefore, appropriate for the provincial licensing bodies to confer this privilege upon such an individual.

For Council to do this, it must first define, in measurable terms, what those requirements are. The task is not an easy one, but this Council is unique in that its members represent all the Canadian resources in medical education, as well as having a close liaison with those responsible for the licensing of physicians. With such resources, the task, although formidable, is not impossible.

This task, of course, is one of great concern to many organizations involved in medical education evaluation. Faced with the enormity of the task, one cannot help but ask: Why us? The answer is not only because it is our clear mandate, but also because,

*Address delivered on September 17, 1984 at the 72nd Annual Meeting of The Medical Council of Canada, Château Laurier, Ottawa.

**Mailing Address: McMaster University Medical Centre, 1200 Main Street West, Hamilton, Ontario, L8N 3Z5

thanks to the wisdom of our founding fathers, our organization is uniquely constituted to achieve this objective. I will quote from Liz Hillman's address of a few years ago:

"I believe that the Council, by its constitution and its composition, is equipped to develop and enforce standards on a national basis. There is no other Canadian medical body which has the legal authority to do so at the general licence level. There is no other Canadian medical body, made up of representatives of licensing bodies and of medical schools for the express purpose of establishing a qualification in medicine, which will be acceptable to the provincial medical boards for licensure, and which is a means of protecting the public against incompetent physicians. With good will, persistence, with knowledge of each other's problems and concerns, and with co-operation and honest effort, there is no reason why the Council cannot establish and maintain standards which will enhance the relevance of the LMCC."

But, like any individual, we cannot and should not stand alone; we must recognize our interdependence with other organizations in achieving mutual objectives. Dr. Bill McClure this year has provided for Council a brilliant example of what can be achieved in that spirit enunciated by Dr. Hillman. In close collaboration with our colleagues in the APMC and the Federation of Provincial Medical Licensing Authorities, we appointed a joint committee which has taken what Bill modestly termed a first step by accepting the principle that it is appropriate that the Medical Council should expect, upon receiving official notification of the satisfactory completing of the PG-1 year, that certain essential characteristics will have been carefully measured at the level of the individual program.

In a similar fashion, I would suspect that, as this task is addressed, there will be many other areas within the characteristics identified as combining to produce what we know as clinical competence many characteristics that may well exist in, or be absent from, individuals before they even get to medical school, and, clearly, through our representatives in the medical schools, we should assist in identifying those characteristics, and aid and support them in their continuing efforts in the process of admission to medical schools in the first place.

There is no argument but the development of curricula is clearly the responsibility of medical schools across Canada, and we look to their very active involvement in helping us to define the elements of clinical competence developed, or expected to be developed, in undergraduate medical programs, and in developing way of making appropriate evaluation.

It goes on, then, by axiom, that the further development of such characteristics at the level of PG-

1 year and specialty programs is a prime responsibility of other organizations, but there again, in our identification of what it is appropriate to measure at the level of the basic undifferentiated physician, I am sure that we can help to further define those elements of clinical competence that require the special attention of the Federation and its constituents and of those responsible for intern and residency education. Certainly, our role should be collaborative and supportive of their undertakings.

Now, each of those organizations has its own unique makeup and objectives, and many of those objectives, as I have said, we share, and we must nurture our relationship with respect and sensitivity.

I think we have had a small experience this past year when as mundane a consideration as the future and continuing location of the Medical Council's offices arose. It was an opportunity and an incentive to really examine the intangible benefits that we have enjoyed, and hope to continue to enjoy, with the informal contacts with related organizations such as the CMA and the Federation with which we share geographical space.

So, where are we in 1984? Well, again appropriately, I think, a wiser man than I, Henry Bland, summed it up a year ago when he said:

"I think we have moved from our basic plan of setting a fair examination to engaging now in an analysis of the very nature of the examination process. While this depends, of course, on the detailed technical studies of the experts in the field. . ."

and listen to this word of caution,

"the final use of the information must, I think, be modulated by the accumulated wisdom and, perhaps more importantly, the compassionate commonsense of Council members.

No matter how erudite and precise the research studies, they will avail us little if they are not seen by the profession, and exemplified by you, the members of the Council, to be clearly reasonable and demonstrably fair."

I have no concern for the future of this organization. It is an exciting and fun-filled parade, and I have had the privilege this past year of doing a bit of strutting and twirling a baton at the head of this parade. In turning the baton over to Dick Baltzan,* I wish him, well. He will bring his own unique mark to the office, and will make his own unique contribution. But, I offer him a word of caution. I have learned that this business of acting as the drum major is all right if, for no other reason, it enhances the respect one enjoys from one's wife and children—at least, temporarily—but the secret of being not just an ordinary drum

*Dr. Richard B. Baltzan, Saskatoon, Sask.

Continued on page 61

Women in Family Practice in the Maritimes

Martha Keniston Laurence,* Ph.D.,

Christine Bourbonniere,** M.D. and Barbara J. Ward,** M.D.,

Halifax, N.S.

INTRODUCTION

The growing female presence in the field of medicine has prompted research directed to women in medical schools including selection of specialty training and profiles in practice.¹⁻¹² Women physicians are reported to be less productive, to earn less money and work fewer hours, do fewer procedures, and assume lesser levels of responsibility than men.¹³⁻¹⁴ Few studies have speculated about the reasons behind the reported altered practice pattern(s) of women. Few studies have focused on women in primary care specifically. There is a need for more extensive data focusing on the impact of women physicians on health care delivery and the system as a whole. The repercussions of both the demographic shift in the medical work force and the altered practice patterns of women physicians remain, for the most part, unknown.

Data on women's styles of practice and productivity levels (generally defined in terms of income per unit time) need to be accounted for in health care planning for the future. Numbers of patients seen, types of patients seen, nature of practice settings, motivation for women to practice as extensively as their male colleagues all need to be taken into account. If there are special issues for women in practice and implications for the future of medical practice as a whole, they need to be considered by admissions and curriculum committees of medical schools. If women physicians' practice profiles indicate heavily concentrated patient populations such as obstetrics and gynecology, the design of family medicine residencies with training in this area becomes important. Such data would help women physicians make well-informed, rational career decisions by giving them an idea of some of the special issues facing women in practice.

Dalhousie University provides the principal training ground for physicians of the Maritime Provinces. The increased numbers of women being

trained at Dalhousie is consistent with the trend at medical schools across Canada. Women comprised 14 per cent of medical graduates in Canada in 1970, and 33.5 per cent in 1981. At Dalhousie one-third of the entering class of 96 in 1981 were women; 40 per cent of the incoming class in September, 1984, were female. Nearly half those entering the family medicine residency training program (20-24 per year) for the last five years, have been women. The impact on the practice of medicine because of the greater numbers of women has yet to be felt since those in practice by the early 80s was still small. Of non-specialist practitioners in the Maritimes in 1982, approximately ten per cent were female. Data were requested from the licensing boards and insurance services for each province in the Maritimes; the approximations reflect the variations and discrepancies between agencies and times of reporting (e.g. 1980 figures for Nova Scotia; 1982 "Study on female M.D.'s in New Brunswick" results). About 155 women practitioners were practising non-specialists in the Maritime Provinces in 1982.

This study, conducted in 1982, addressed the overall question of issues which women in family practice in the Maritimes considered unique. What were they and why did the women doctors think they were unique?

METHOD

The sample population was chosen to represent the various geographic areas of the Maritimes taking into account total population in each province and rural/urban representation. Fifteen interviewees were selected using Dalhousie University's Continuing Medical Education Division's medical registry as the principal source of names. The sample number accounts for approximately 10 per cent of female family doctors practising in the Maritimes. Sample size was dictated by time, budget and belief that it was sufficient to answer questions of the study. Seventeen potential study participants were approached in order to make up the sample of fifteen. Two persons refused to participate: one because of disinterest, one because she was working in an inappropriate setting (mental hospital). Geographic distribution of study participants is shown in Figure 1.

The selected women were mailed a covering letter which outlined the study, invited them to participate,

*Associate Professor, Department of Family Medicine, Dalhousie University, Halifax, N.S.

**Family Medicine Resident, Dalhousie University

This study was funded by the Maritime Family Medicine Research Unit of the College of Family Physicians of Canada.

Correspondence: Doctor M. K. Laurence, Department of Family Medicine, 5599 Fenwick Street, Halifax, N.S. B3H 1R2.

asked them to complete and return, by mail, an attached demographic and personal data questionnaire, and it informed them we would phone to obtain their answer and arrange an appointment for a subsequent telephone interview. Also included was a list of topic areas for the interview: practice profile, lifestyle/personal issues, relationships with male colleagues, and income.

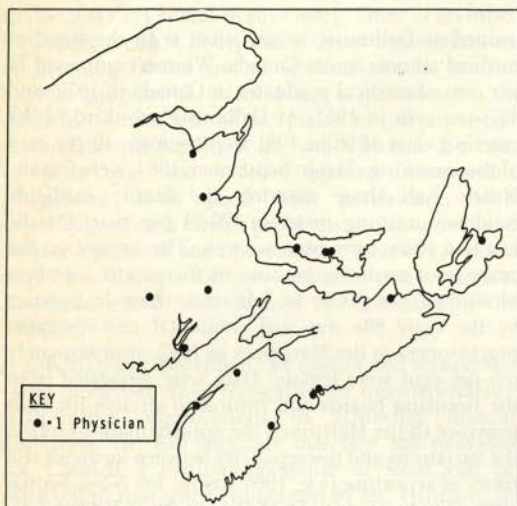


Figure 1. Geographic distribution of the 15 Maritime female physician respondents.

Interviews took place during the months of May and June, 1982. Each of the three investigators interviewed physicians they did not know. Fourteen of the interviews were tape-recorded with consent and transcribed. One participant preferred to not be taped but consented to notes being taken during the interview.

Data from the personal and demographic data questionnaires were tabulated. The transcriptions from the interviews were reviewed by all three investigators who noted frequencies and similarities of responses in each of the identified topic areas.

RESULTS

Part A: Personal and Demographic Data

All participants were in general or family practice and had graduated from medical school between 1967 and 1979 with a median of 1975. All graduated from Dalhousie University except one from Memorial University of Newfoundland. Three were certificants of the College of Family Physicians of Canada.

Thirteen completed questionnaires were returned. All 15 respondents claimed to have returned theirs; since there was no personal identification on the questionnaires it was not possible to trace the missing two.

The women ranged in age from 28 to 41; most were in their early thirties (mean 32.4; median 31). Three had completed residency training in family medicine. One more respondent reported an extra year of training in internal medicine after internship.

Living status showed ten living with spouses or partners, two living alone, one with her mother. Five had no children, two were pregnant with their first child, and six had one to three children each. The children ranged from eight months to eleven years with the median age being four years.

Eight respondents worked full-time, 40 to 80 hours per week, with the median being 55 hours. Five described their practice as "part-time", working 16 to 40 hours per week with a median of 25 hours.

Ten respondents took emergency room duty, 12 assisted in the O.R., ten participated in a sign out system, and one signed out but did not take call.

Information on their practices is shown in Table I.

TABLE I
WOMEN PHYSICIANS' PRACTICE PROFILES (N=13)

	Range	Median	Mean
No. years in community	8 mos.-11 yrs	3 yrs.	5 yrs
Partnership practice: 10 No. in group	2-12	2	-
No. patients	630-5000	1100	3000
Percent female	30-90	70	65
Percent obstetrics & gyn.	2-75	15	25
Percent pediatrics	9-60	25	28.7
Percent geriatrics	2-50	10	14.8

Part B: Interview Data

The issues identified are grouped in the four broad categories suggested to the 15 interviewees. A fifth category emerged from the data analysis.

A. Concerning their practice profiles, the physicians felt:

1. They saw more young female patients for obstetrical and gynecological care than their male colleagues. (9)
2. They had a disproportionately high obstetrical and gynecological practice. (10)
3. Their pediatric caseload was particularly high. (7)

Three respondents regretted having so few young male patients. Two reported too many "incomplete" (i.e. father not part of practice) families. Several commented on the number of older women they saw for a first ever pelvic examination.

B. Lifestyles/Personal Issues:

The physicians identified problems which they felt were unique to them as women:

1. Finding and maintaining a balance between family organization and responsibilities and career. (7)
2. Child care coverage. (3)
3. Finding housekeepers. (4)
4. Difficulty having any personal life because of
 - a) work demand (obstetrics, 24-hour call, home visits) (2)
 - b) unmarried, small town. (1)

C. Concerning their relationships with male colleagues, the physicians:

1. Felt a high degree of acceptance. (11)
2. Stated that while there was no present problem, they encountered initial exclusion and needed to prove themselves, "pull their weight", and had to deal with skepticism about their intentions to practice and have a family. (9)
3. Felt wanted and needed because they were
 - a) female (3)
 - and/or
 - b) local person returning (3)

D. Income:

1. Some physicians felt that their income was the same as that of male colleagues (4)
2. Some physicians felt that their income was lower because
 - a) they worked fewer hours or limited hours (3)
 - b) they spent more time per patient (6)
 - c) they had a high obstetrical load, for which their province's fee is low (1)

Of those who worked fewer hours and spent more time with patients, three felt less pressure to earn more money since they were not the sole income earner in the family, two liked and did considerable counselling, three described it as a life-style choice.

E. The physicians felt that their patients chose them because:

1. They were women
 - a) absolutely (8)
 - b) maybe, partially or initially (6)
2. They were thorough and spent more time with the patients (5)
3. They were willing to do counselling (3)
4. They had characteristics such as personality,

affability, honesty, empathy, warmth, listening, skills, understanding (11)

5. Organization and/or situational reasons such as being well-known previously in the community, having taken over a practice or being part of a well-known group, part of a sign-out system (6)

DISCUSSION

Did women in family practice in the Maritimes identify issues they considered special because they were women? Generally, yes. In terms of practice profile most respondents felt they saw more young women than their male colleagues. Those who enjoy obstetrics and gynecology said they were content with this situation; others expressed dissatisfaction. A few commented that they saw the women and children in a family while the father sees a male colleague. A couple expressed frustration by these "incomplete" families.

Several physicians felt their high female patient population was due to the fact they were the only female practitioner in their area. Accounts of older women coming in for a first-ever pelvic examination were reported by several physicians, particularly those practising in rural areas. Two or three felt they saw a greater share of the unwed, pregnant women as well as the adolescents wishing contraceptive advice than the other practitioners in the community. Most interviewees felt that the nature of their patient population was influenced by the fact that they were women.

The issue that sparked the greatest amount and most impassioned commentary was that of lifestyle. Most of the interviewees said that dividing themselves between their personal and family lives and their medical career presented real problems. Some felt they were "short changing" both their practices and their families. Others said that, although arranging their lives demanded great time management skills and flexibility from all concerned, they were generally satisfied with the way things were going for them. The physicians doing considerable obstetrical work found this a tremendous burden on their lifestyle, as most did not "sign out" their obstetrical caseload. It put considerable strain on all personal and family plans.

Child care was especially difficult because physicians' irregular hours made day-care and regular baby sitters impractical. Several women relied heavily on their mothers or other members of their extended family to care for their children at these times. One physician stated that the only reason she managed was that she shared her practice with her GP husband. The problems of managing a professional career and the demands of family and domestic life would seem to be similar to those expressed by women in any profession.¹⁵ The added burden of irregular and

unpredictable hours for the physicians may make for greater problems.

Collegial relationships were a non-issue for most physicians who reported feeling high acceptance by male colleagues. Several stated that there were initial difficulties but that once they had gone on to prove themselves, good relations had ensued. One stated that she had had to prove herself because of the town's bad experience with a female GP in the past. For the most part, however, the physicians agreed that it was difficult to sort out how much initial animosity was related to being new in town versus being a woman.

Physicians interviewed were divided on the issue of income. One quarter made salaries comparable to that of male counterparts. The rest attributed their lower wages to differing practice styles. Contributing factors were felt to be spending more time per patient and doing a high volume of low paid work, e.g. obstetrics in P.E.I. Three physicians commented that they felt less pressured to earn money because they were not the family's primary income earner. On the whole, the women interviewed were not particularly concerned with salary issues.

The physicians were asked why they felt patients chose them. Nearly all of them responded that their being women played some role in patient's selection. Most went on to qualify this statement by saying that this was the reason for the initial choice but patients remained in the practice because they were satisfied with the quality of care. A third said that a positive feature was her willingness to do counselling. Five prided themselves on their thoroughness and felt that this feature especially brought patients to them. Six physicians cited other reasons, such as being from the town, having taken over a practice, and being part of a well-known medical group. Many listed characteristics often associated with being women in our culture — e.g. warmth, empathy, understanding — and which patients have reported as desirable in a physician.¹⁶ These women physicians saw themselves as different from the patients' point of view and that being a woman was important to their patients.

Although women may be deemed "less productive" in terms of the number of patients seen and dollars generated, the issue of quality of care is absent from most reports. The women in this study reported seeing patients for activities considered important to health maintenance such as Pap smears and routine pelvic examinations. The physicians reported that they themselves initiated the topic if their female patients did not. They also reported high incidence of women coming for that specific purpose and expressing their previous discomfort at the idea of mentioning it to their male physicians who reportedly did not initiate it either. This may indicate an area of health care most certainly within the preserve of primary care providers

which is and will be effected by more women in practice.

From the women in this study it would appear that the altered patterns of practice were reflected in two major areas, each of which represents choices on the part of the physician. First was in the practices themselves. They felt the type of patients and kinds of problems they saw, plus their approach to patient management, reflected a chosen style of practice which included spending more time with patients. Thoroughness, a sense of availability and emphasis on their interpersonal relationships with patients were felt to be important for them to be "good" physicians. One might postulate that the kinds of patient problems they encounter in greater abundance may require the same from any physician.

The other choice area reflected quality of life issues for the women themselves either as individuals or as family members. It may be worth speculating whether more male practitioners are making similar kinds of choices and concerns, for quality of lifestyle may be a reflection of the times. However, for some of the women interviewed, the "less productive" practice was their chosen solution to the multiple demands of two jobs (family and practice), a solution often tempered with an element of struggle. The newly visible group of women practitioners is in its childbearing period and whether or not these physicians continue to work less in later practice life, then they are freer of family management pressures, remains to be seen. In attempting to deal with the long range manpower problems it is difficult to know whether the previous definitions of "productivity" will apply to anyone — male or female. In any case, to evaluate the service contributions of women physicians, we may consider that in all likelihood they will at least be practicing longer — if differently. □

Post-Script: Appreciation is expressed to the Atlantic Family Medicine Research Unit for funds to support this initial investigation into the experience of women physicians in family practice in the Maritimes.

Further investigations would hopefully reflect the views of male physician respondents and the dramatically increasing proportion of women in practice as we approach the late 1980s. M.K.L.

References

1. Notham MT, Nadelson CC: Medicine: a career conflict for women. *Am J Psychiat* 1973;130:1123-1127.
2. Ryten E: A statistical picture of the post-MD clinical training of physicians in Canada. *ACMC Report*. Ottawa: Health and Welfare Canada, 1980-81.
3. Love R: Women in Medicine: will it make a difference? *Healthsharing* 1981;(Fall):14-17.

Continued on page 61

Visceral Kaposi's Sarcoma Masquerading as Inflammatory Bowel Disease: A Case Report

R. S. Dunn,* M.D., F.R.C.S.(C), F.A.C.S.,

Sydney, N.S.

INTRODUCTION

Kaposi's sarcoma is a rare malignancy involving primarily the skin, although multi-organ system involvement has been reported in many papers. Throughout North America, there has been a rather abrupt increase in patients being diagnosed with this condition. This has been recognized to be associated with the Acquired Immune Deficiency Syndrome (AIDS) which has stimulated a vast amount of research and inquiry in North America.

We present a case study of an individual who does not fit the characteristics of patients who usually acquire AIDS or appear to be in a high-risk category, even when the epidemiology of the disease is considered on a world-wide basis. Occasionally the disease may be present in primarily a visceral form without any predominance of skin lesions and, when the symptomatology mimics gastrointestinal disease, difficulties in diagnosis can occur as the following presentation will outline.

CASE HISTORY

A white 55 year old male presented initially to his family doctor with complaints of diarrhea and intestinal cramps, which were mild in nature and for which he was treated symptomatically. Over the following weeks and months, the symptoms became worse and further investigations were carried out. These included CBC, sedimentation rate, chest Xrays, and eventually a barium enema was performed at another hospital. All tests were apparently reported as normal.

The patient did experience considerable discomfort at the time of the barium enema and refused any further such investigations. Nonetheless, his clinical course continued to suggest inflammatory disease of the large bowel for which he was treated with Salazopyrin® with minimal improvement. Crampy abdominal pains and diarrhea continued and a gastroenterologist was consulted. This general line of treatment was continued and steroids were added to this regimen. A sigmoidoscopic examination showed considerable mucosal change which was felt compatible with an inflammatory bowel disease.

Several months had now elapsed since the original complaint and the patient had lost about 15% weight. He was quite miserable with persistent diarrhea and now some blood appeared in his stools. Repeat sigmoidoscopy was carried out and heaped-up friable-looking lesions in the rectum were noted now by the gastroenterologist who, for the first time, considered another diagnosis, possibly a malignancy.

For this reason an opinion was sought from a general surgeon (RSD). On the day the surgeon was due to make an assessment of the patient, he found the patient acutely short of breath, tachycardic, with depressed blood pressure, and a swollen left leg. The clinical diagnosis was one of pulmonary embolism. He was treated with heparin. A lung scan was positive and it appeared that he had developed a deep venous thrombosis in his left leg, with pulmonary embolism. This delayed further investigation of his bowel problem and he was discharged from the hospital after two weeks, to continue on warfarin therapy.

His gastrointestinal (GI) complaints continued, however, and he simply could not manage at home because of intractable diarrhea, despite a variety of medications. Therefore, warfarin was stopped and a biopsy of his rectum was carried out when prothrombin times were close to normal. Reports were submitted and three separate opinions were obtained regarding the pathology. Two pathologists agreed the specimen was most likely a leiomyoma. The third suggested that this was "chronic colitis with ulceration suggestive of ischemic origin". This latter report did seem consistent with a severe case of Crohn's colitis.

The patient continued to deteriorate and was admitted to his local hospital when he became febrile. He was transferred to Sydney City Hospital where broad-spectrum antibiotics, including Flagyl® and Tobramycin® were instituted. He continued to appear toxic and steroids were added. None of these measures seemed to alter the course of his disease substantially and he remained toxic and febrile, now with abdominal tenderness and a high white count.

There seemed little choice but to consider resection of the involved colon in an effort to save this man's life and he was taken to the operating room with plans to do an abdominal-perineal resection on May 17, 1984. Laparotomy was carried out first and it was noted that there was an intense bluish induration and

*General and Vascular Surgeon, 146 Whitney Ave., Sydney, N.S. BIP 429

thickening with what appeared to be an intramural hemorrhage involving all the sigmoid and descending colon. A long segment of transverse colon was spared but in the right colon another large patch of the same process was noted. Parts of the sigmoid colon appeared frankly necrotic and there was a small amount of blackish fluid within the abdominal cavity. In this circumstance all the colon was removed, including the rectum, and ileostomy was performed. There did not appear to be any involvement of the small bowel, duodenum, or stomach.

Post-operatively a full-blown disseminated intravascular coagulation developed with elevated prothrombin times, depressed platelet count, and elevated fibrin split products. It was necessary to transfuse platelets over a 48 hour period, as well as several units of blood and fresh frozen plasma. After 48 hours he was returned to the operating room to drain an accumulated hematoma which resulted when the DIC was at its peak.

After this the patient's course settled down somewhat and he developed no further life-threatening problems for the rest of his hospital stay. Soon a pathology report on the colonic specimen was returned suggesting Kaposi's sarcoma and this was confirmed a few days later with a referral to the Area Laboratory in Halifax.



Figure 1. Cross section through the gross specimen of colon. Tremendously thickened heaped up mucosa and submucosa is demonstrated.

Figure 1 is a photograph of a gross specimen of part of the sigmoid colon. The tremendously heaped-up and thickened tissue in the ileum is well demonstrated. At this point his original barium enema, performed several months previously, was obtained from the outlying hospital. This was reviewed by our radiologist who agreed that there

were, in fact, abnormalities on this film. Figure 2 illustrates part of the sigmoid loop which appears to show a definite polypoid filling defect and mucosal changes throughout this segment of bowel.

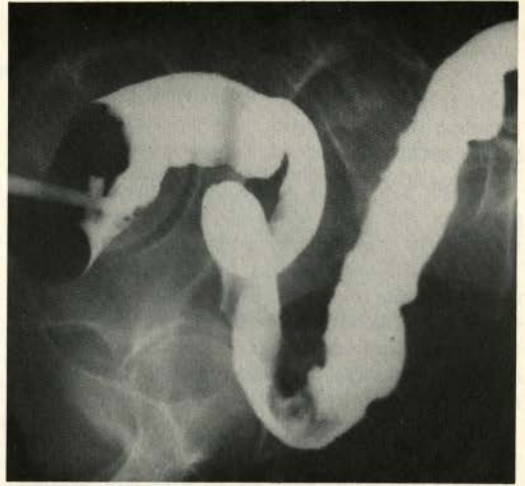


Figure 2. Barium enema demonstrating, in retrospect, a polypoid filling defect in sigmoid colon, and some mucosal abnormalities.

During his critical illness and post-operative stay, this man began to develop obvious subcutaneous lesions in a few areas on his body. These were bluish, raised, firm areas which were originally assumed to be due to ecchymosis or hemorrhage at the time of his coagulopathy. However, when the report of Kaposi's sarcoma was established, a small lesion on his lip was completely excised under a local anesthetic and was also reported as typical cutaneous Kaposi's sarcoma. Figure 3 shows one of these cutaneous lesions in a digit, left fifth finger.

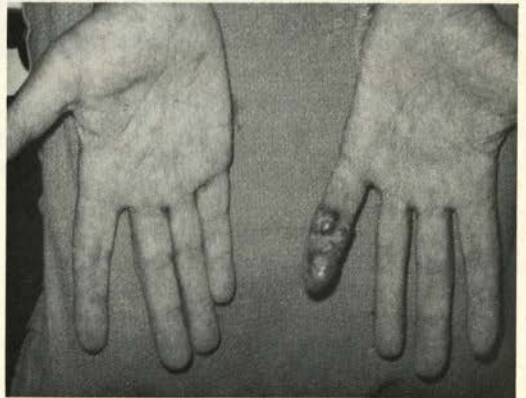


Figure 3. Cutaneous lesion on 5th finger, left hand, which appeared during hospital stay.

Once this information was accumulated and the patient's clinical course had stabilized, the Cancer Research Foundation in Halifax was contacted by telephone and, after some consideration, a course of VP-16 100 mg weekly was recommended and instituted. Initially the patient responded with some elevation of his bilirubin and a sharp drop in platelet count and the second course had to be withheld. Following that, all subsequent courses seemed to be tolerated without such problems and he was eventually discharged with follow-up arranged and the VP-16 to be given weekly by his family physician.

The discharge date was July 7, 1984 and his total hospital stay had been about 7 weeks. Since that he has been reassessed 3 times by myself. He has gained 23 pounds in weight. His energy has returned to the level where he can walk 2 miles at a stretch without stopping. He is, of course, completely self-sufficient looking after his ileostomy and in managing the affairs of his life. All of his skin lesions have completely subsided and lost the bluish color and induration, leaving only a brownish pigmentation without any elevation in the skin.

DISCUSSION

This case would appear to be noteworthy in several respects. First of all, this man does not appear to fit the usual epidemiologic considerations to contract this disease in the first instance. Many indepth reviews of Kaposi's sarcoma have appeared in the last few years sparked by the interest in its correlation with AIDS. A review by Modlin *et al.* points out that the annual incidence is somewhere around .02 to .06 per 100,000 population in the United States with a male/female ratio of 15 to 1.¹ However, their findings were very similar to those of Laor *et al.*² and Mitsuyasu *et al.*³ in that the ethnic groups most likely to be involved with this condition are those of Italian and Jewish descent. The form occurring in African blacks appears to be the most predominant on a world-wide basis, but is not seen in North American blacks. Our patient has no major ethnic origin in any of these groups, although there is a connection with some ancestors from the Mediterranean area who were French in origin. Nor does he have any history of contact with the homosexual community as far as can be determined.

He does not seem to be subject to opportunistic infections which might suggest an immune deficiency syndrome and since treatment of his condition has assumed a normal level of activity.

The case is also unusual in that he presents with a rare form of the disease; namely, almost entirely colonic involvement. This topic has been reviewed specifically by Rose, *et al.* of cases mostly related to patients who had contracted AIDS and were all known homosexuals.⁴ In this particular group 48% were found to have some GI tract involvement. In a

radiological review published by Wall, *et al.* almost 50% of a group of patients with a Kaposi's syndrome and also AIDS were noted to have some GI tract involvement.⁵ However, when a group of patients with Kaposi's sarcoma not particularly related to AIDS is examined, as described by Brauer, *et al.* only 10% of the patients were found to have visceral lesions which may involve the GI tract, liver, lung, or heart.⁶ Since our patient has no obvious connection with the AIDS subgroup, his presentation with extensive colonic Kaposi's sarcoma must be regarded as rare.

Visceral involvement in Kaposi's sarcoma has usually been described as a late manifestation of this disease. It has been assumed to represent an expression of the multi-centric potential of this disorder rather than metastasis from a primary site. Most reviews suggest that the more a group of patients with cutaneous Kaposi's sarcoma is studied, the more GI tract lesions will be found. However, it is distinctly unusual for a patient to present with symptomatology in the GI tract as the first indication of the disease.³ Symptoms do not usually occur until the submucosal process extends widely into the muscularis, lamina propria and the mucosa, leading to protein loss, diarrhea, intestinal obstruction, and septicemia.

A further interesting aspect of this man's case history to date is his impressive response to his chemotherapy. Several classification schemes of Kaposi's sarcoma have been advanced and it is probably fair to say that none has widely been accepted. Nonetheless, a very general classification as outlined by Mitsuyasu, *et al.* seems valid to the disease as it is currently understood.³ (See Table I). This classification roughly described the amount of tumor burden in a particular patient. The worse prognosis has generally been linked to the Stage IV disease — those having cutaneous and visceral involvement. This would indicate a very poor prognosis for our patient, but it is worth noting that there has been considerable variance in the literature with respect to prognosis, with few "hard" data available providing accurate survival estimates.

TABLE I
CLASSIFICATION OF KAPOSI'S SARCOMA³

Classification	Criteria
Stage I	Limited cutaneous (one anatomic area)
Stage II	Disseminated cutaneous (more than one anatomic area)
Stage III	Visceral only (gastrointestinal, lymph nodes, etc)
Stage IV	Cutaneous and visceral

It is recognized that Kaposi's sarcoma in the setting of AIDS is generally aggressive, with early involvement of lymph nodes and viscera. Classical

Kaposi's sarcoma is supposed to be the more indolent disease associated with survival times of 8-13 years. Many patients develop a second malignancy and GI tract involvement is not as common as it is in AIDS associated Kaposi's. In any event, treatment of this condition has generally been with radiotherapy since the tumor is usually exquisitely radio-sensitive. This is particularly appropriate for patients in which the involvement is largely cutaneous. Chemotherapy has been used not only as a single agent but also in combination chemotherapy. This is somewhat dangerous in AIDS patients who are already immunosuppressed. Most investigators have opted for single agent chemotherapy. Laubenstein and his co-workers⁸ have demonstrated an excellent objective response to VP-16, and confirmed by Mitsuyasu, *et al.*³

Though our patient did have a definite thromboembolic episode, no literature I read suggests an increased incidence of deep vein thrombosis or pulmonary embolism in Kaposi's sarcoma, although involvement of superficial veins with this disease process has been mentioned.

The underlying causes of Kaposi's in AIDS are well beyond the scope of this case report. Suffice it to say that viral etiologies have been mentioned including CMV and Barr-Epstein virus. Our patient was tested for both of these and his titres were low.

SUMMARY

We have presented a case of a 55 year old white male of possible Mediterranean background who appeared to present with a case of classical Kaposi's sarcoma with visceral involvement. His initial symptoms were those of GI tract pathology, namely diarrhea, weight loss, and bleeding per rectum. He had complicating pulmonary embolism prior to his diagnosis and a few skin lesions appeared very late in his clinical course only. His general presentation was very similar to a granulomatous colitis with involvement of only segments of the large bowel. The literature relative to this case has been reviewed and it would appear that Kaposi's sarcoma is a very rare cause of progressive diarrhea in a previously healthy male. In retrospect, the failure of this patient to respond to any of the standard medications used in the treatment of inflammatory bowel disease was probably a good reason to consider other diagnoses. It is worth stressing the fact that biopsies taken with standard forceps in the rectum and sigmoid areas probably failed to provide a diagnosis because the lesions are generally submucosal, further adding to the difficulty of making a histological diagnosis. The endoscopic appearance, however, may be highly suggestive if one has a high index of suspicion.⁷ Biopsies do, however, help to rule out adenocarcinoma or ulcerative colitis which are far more common entities.


It is possible that in the years ahead, with the increased incidence of AIDS-related Kaposi's, more patients with colonic involvement may be seen in Nova Scotia. This condition then should be added to the differential diagnosis in patients with what appear to be severe inflammatory lesions of the colon which do not respond to classical treatment, and in which at time of endoscopy or radiologic investigations have a bizarre appearance. □

ACKNOWLEDGMENTS

The author acknowledges with gratitude the work of Dr. Anitra Laycock at the Halifax Infirmary in locating articles relevant to this paper. Also the contributions of Dr. D. Glasgow and Dr. R. Mathieson, pathologists at Sydney City Hospital were very helpful. The cooperation of Dr. J. Roach, the family physician in this case, was very much appreciated, as were the efforts of Mrs. Jan Terry in preparation of the manuscript.

References

1. Modlin R L, Crissey, J T and Rea, T H. Kaposi's Sarcoma. *Int J Dermatol* 22:443-448, 1983.
2. Laor Y and Schwartz R L. Epidemiologic Aspects of American Kaposi's Sarcoma. *J Surg Oncol* 1979; 12:299-303.
3. Mitsuyasu R T and Groomman J E. Biology and Therapy of Kaposi's Sarcoma *Seminars in Oncology*. 1984; 11:53-59.
4. Rose H S, Balthazar E J, Megibow A J, Horowitz L, and Laubenstein L J. Alimentary Tract Involvement in Kaposi's Sarcoma: Radiographic and Endoscopic Findings in 25 Homosexual Men. *Amer Roentgen Ray Soc.* 1982; 139:661-666.
5. Wall S D, Friedman S L, and Margulis A R. Gastrointestinal Kaposi's Sarcoma in AIDS: Radiographic Manifestations. *J Clin Gastroenterol* 1984; 6:165-171.
6. Brauer M K, Gates P E, Doyle J L, and Paterson N J. Visceral Kaposi's Sarcoma Presenting With Gingival Lesions. *Oral Surg* 1980; 50:151-155.
7. Weprin L, Zollinger R, Clausen J and Thomas F B. Kaposi's Sarcoma: Endoscopic Observations of Gastric and Colon Involvement. *J Clin Gastroenterol* 1982; 4:357-360.
8. Friedman-Kien A E, Laubenstein L J, Rubinstein P *et al.* Disseminated Kaposi's Sarcoma in Homosexual Men. *Ann Intern Med* 1982; 96:693-700.



ALFRED J
BELL & GRANT Limited
INSURANCE SPECIALISTS

bank of montreal tower, george street, (p.o. box 8)
halifax, nova scotia (902) 429-4150, telex 019-21713

"INSURANCE — THAT'S ALL!"

RETIRING PRESIDENTS ADDRESS

Continued from page 52

major but an exceptional drum major is to remember, after all the skills of twirling and strutting have been developed and honed to a fine edge, to occasionally glance back over your shoulder to make sure the parade is still behind you.

It is with pleasure that I turn over this office to Dick and, in doing so, I add my thanks to him for the wonderful support and help we have grown to expect from Dr. Wilson Leach and his staff, for the efforts of the Examination Board, and for the continued goodwill and expert advice of the McLaughlin Centre. Finally, I should like to express my real appreciation for the enthusiasm, wisdom and common sense displayed by Council members in general. □

WOMEN IN FAMILY PRACTICE IN THE MARITIMES

References continued from page 56

4. Roeske NA, LAKE K: Role models for women medical students. *J Med Ed* 1977;52:459-466.
5. Fletcher SW: Women physicians: old times or a new era? *The Pharos* 1982;(Winter):2-9.
6. Vincent MO, Hill, MM, Tatham MR: Why female physicians? *Ontario Medical Review* 1976;(July):339-341.
7. Davidson VM: Coping styles of women medical students. *J Med Ed* 1978;53:902-907.
8. Owen G: The Occupational content of family medicine in Ontario 1982. Ontario Chapter, College of Family Physicians of Canada, 1982.
9. Relman AS: Here come the women. *N Engl J Med* 1980; 302:1252-1253.
10. Ferrier BM, Woodward CA: Career choices, work patterns and perceptions of undergraduate education of McMaster medical graduates: comparison between men and women. *Can Med Assoc J* 1982;126:1411-1414.
11. Guzman CA: Medical womenpower and the profession. *Ann R Coll Phys Surg Can* 1981;14:281-285.
12. Ward AWM: Careers of medical women. *Br Med J* 1982;284:31-33.
13. Tatham MR, Hill MM, Vincent MO: Women physicians: a wasted resource? *Can Doctor* 1977;(Jan):24-27.
14. Heins M, Smock S, Jacobs J, Stein M: Productivity of women physicians. *JAMA* 1976;236:1961-1964.
15. Whitfield MD: Stresses associated with career success for women. *Can Psychiatr Assoc J* 1978;23:9-13.
16. Gray J: The effect of the doctor's sex on the doctor-patient relationship. *J R Coll Gen Pract* 1982;32:167-169.

DAVIDSON

LET'S
SEE
YOU
DO
IT!



PARTICIPACTION ©



Personal Interest Notes

A group of Halifax physicians has been named one of seven Canadian teams to take part in an international study with five European teams in an experimental treatment of juvenile onset, or Type One, diabetes. **Dr. Meng Tan**, Professor of Medicine, Dalhousie Medical School, will direct the Halifax trials. Other physicians on the Halifax team are **Drs. Sonia Salisbury, Allan H. Shlossberg, and Alan MacDonald**. Dr. Tan is Head of the division of endocrinology in the Department of Medicine and Director of the Diabetes Clinic at the Victoria General Hospital, Halifax.

Dr. Rolph Sers, Antigonish, was presented Life Membership in the Canadian College of Family Physicians at their annual meeting in May.

NEW DEAN OF MEDICINE

Dr. T.J. (Jock) Murray, Professor of Medicine, was named new Dean of the Faculty of Medicine at Dalhousie University.

Dr. Murray, whose appointment is effective Aug. 1, succeeds Dr. J. Donald Hatcher, who has been Dean since 1976.

Dr. W. Andrew MacKay, President of Dalhousie University, made the announcement Friday. He said Dr. Murray's appointment was recommended after consultation within the medical school and with representatives of the teaching hospitals with which Dalhousie is affiliated.

Born in Halifax, Dr. Murray received his early education at Pictou Academy. He took his pre-medical training at St. Francis Xavier University and obtained his M.D. at Dalhousie in 1963.

After two years in general practice in Nashwaaksis, N.B., he returned to Dalhousie for post-graduate work in internal medicine and neurology. Then, as a commonwealth scholar, he studied at the Institute of Neurology at Toronto General and St. Michael's Hospital in Toronto.

In 1969, the year he joined the faculty at Dalhousie as a lecturer in medicine, he was appointed a fellow in neurology at Victoria General Hospital, Halifax.

In 1972 he was promoted to assistant professor and appointed consultant in neurology to the Victoria

Dr. J. Donald Hatcher, Dean of the medical school, Dalhousie University, will receive an honorary L.L.D. from Queen's University in Kingston, Ontario on May 25. Dr. Hatcher had been Head of the Department of Physiology and Associate Dean at Queen's University before coming to Dalhousie nine years ago as Dean of Medicine.

Dr. Hatcher, a Markle Scholar in Medical Science at Queen's University from 1952 to 1957, graduated from the medical school at the University of Western Ontario in 1946 and received his PhD from Western in 1950.

Dr. G. Enid MacLeod, Dartmouth, Professor Emeritus of Physiology and Biophysics at Dalhousie and a pioneer in the use of curare as a muscle relaxant, received an honorary doctor of laws degree at the convocation for the faculty of medicine on May 17. She was born in Jacksonville, N.B., and received her M.D., C.M. from Dalhousie in 1937. In 1960 she joined the Department of Physiology and Biophysics at Dalhousie, retiring in 1976. She was appointed Professor Emeritus in 1980. At 74 Dr. MacLeod remains active. She is secretary of the local University Women's Club, Federation of Medical Women of Canada, and Clan MacLeod Society.

General, Camp Hill and Grace Maternity hospitals and Nova Scotia Rehabilitation Centre, and director of neurological services at Camp Hill. Two years later he became associate professor then professor of medicine.

In addition to his major appointments as professor of medicine and head of the division of neurology at Dalhousie, Dr. Murray is director of the Royal College program in neurology, an associate professor in the Faculty of Health Professions and in the Department of Family Practice, director of Dalhousie's multiple sclerosis research unit, an honorary professor of the School of Physiotherapy and an honorary consultant to London Hospital, London, England.

He is a fellow of the Royal College of Physicians and Surgeons of Canada, American College of Physicians and Royal Society of Medicine (London), and vice-president of American Academy of Neurology.

He is also a member and past-president of Canadian Neurological Association and is governor-elect of American College of Physicians.

He is married to the former Janet Pottie, Halifax, who has served as chairman of the board of governors, Mount Saint Vincent University. Dr. and Mrs. Murray have two sons and two daughters, Bruce, Brian, Suellen and Shannon.

By Judith Myrden

Reprinted with permission The Halifax Herald, May 17, 1985.

**THE DALHOUSIE
MEDICAL RESEARCH FOUNDATION**

Grants for equipment and personnel support valued at close to \$300,000 were approved by the board of directors of The Dalhousie Medical Research Foundation at its March meeting, held at Dalhousie Medical School, Halifax. Scholarships of \$10,000 each over two years were awarded to four first-year medical students. They are:

— **Sultan Darvesh**, 28, BSc., MSc., PhD., (UNB), formerly of Tanzania, now of Halifax. He will work with Dr. David A. Hopkins, department of anatomy, studying neural control of the heart.

— **Robert B. Fraser**, 24, BSc., (Acadia), of Windsor, N.S., who will do research in pancreatic transplantation for diabetics with Dr. M.A. MacAulay, head of the department of pathology.

— **Pamela A. Brown**, 20, BSc, Hons., (Acadia) of Amherst. She will take part in research into heart disease in the laboratory of Dr. J. A. Armour, department of physiology and biophysics, and cardiologist Dr. D. E. Johnstone, department of medicine.

— **Manoj Vohra**, 21, BSc., (Dal), Halifax, who will study electrophysiology of the heart in the laboratory of Dr. T. F. McDonald, department of physiology and biophysics.

Fellowships valued at \$112,872 were awarded to four post graduates. Three of the awards were made under the terms of the Lalia B. Chase bequest and one was a Patton Medical Research Scholarship. The winners were **Dr. Patricia W. Nance**, **Dr. John C. Marshall** and **Dr. Richard I. Hall** (Lalia B. Chase Fellowships) and **Dr. John H. MacGregor** (Patton Fellowship).

The equipment grants amounting to \$143,550 were made to **Dr. K. Easterbrook**, department of microbiology; **Dr. R. Rajaraman**, medicine and microbiology; **Dr. David E. Cole**, paediatrics; **Dr. R.W. Chambers**, biochemistry; **Dr. W.H. Moger**, physiology and biophysics; **Dr. P.C. Jackson**, anatomy; **Dr. L.A. Fernandez**, medicine; **Dr. Matthew W. Spence**, paediatrics; **Dr. K.W. Renton** and **Dr. M.M. Vohra**, pharmacology; **Dr. R.I. Carr**, medicine and microbiology, and a Foundation Associateship winner in 1982; and **Dr. J. Verrier Jones**, medicine.

In the past four years, the Foundation has awarded a total of \$675,067 from its capital equipment fund to medical researchers; 22 medical students have received scholarships to enable them to perform research during student years and 14 graduates have won Fellowships.

By Barbara Hinds

□

OBITUARIES

Dr. Abraham R. Gaum, 75, of Sydney, N.S. died on April 19, 1985. Born in Sydney he received his medical degree from Dalhousie University in 1934. He was a physician and surgeon in the Sydney area for more than 50 years. He was a senior member of The Medical Society of Nova Scotia and The Canadian Medical Association, and served as a member of The Provincial Medical Board. He helped initiate and finance the renal dialysis unit at the Sydney City Hospital and was honored by the Sydney Medical Society for his outstanding service to his community. The *Bulletin* offers sincere sympathy to his wife and family.

Dr. John Fabian Bates, 89, of Sydney, died in Brantford, Ontario on May 13, 1985. Born in Sydney, he was a graduate of St. Francis Xavier University and Dalhousie University. He practised medicine in Glace Bay from 1926 until his enlistment in 1940. Returning from overseas in 1945, he was with Camp Hill Hospital, Halifax and Point Edward Hospital in North Sydney. In 1949, as Chief Medical Advisor to the Canadian Pensions Commission, he moved with his family to Ottawa. In the late 1970s he returned to Cape Breton. He is survived by a daughter, Halifax, and a son in Ontario. Our sympathy is extended to his family.

Dr. Narendra K. Sinha, 42, of Bedford, N.S. died on May 1, 1985. He received his medical degree in Allahabad, India in 1967. He arrived in Canada in 1974 and practised in Barrington, N.S. before his move to Halifax where he became active at the Halifax Civic Hospital. He was a member of the Medical Society of Nova Scotia, The Canadian Medical Association and the College of Family Physicians. He is survived by his wife, two daughters, and a son, to whom we extend sincere sympathy. □

ADVERTISERS' INDEX

Bell and Grant Limited.....	60
"C" Realty Ltd.....	45
Doane/Raymond.....	43
Janssen (Hismanal).....	44
Kitz Matheson.....	41
Mead Johnson Canada (Prosobee).....	OBC
Medical Practice Productivity.....	41
Professional Economic Consultants.....	43
Classified.....	43,45

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION OF THE CANADIAN MEDICAL ASSOCIATION

MEMBERS OF EXECUTIVE COMMITTEE

OFFICERS

President	M.G. Shaw
President-Elect	J.C. Kazimirski
Past President (Immediate)	R.D. Saxon
Chairman, Executive Committee	V.M. Hayes
Vice-Chairman, Executive Committee	R. Stokes
Treasurer	W.H. Lenco
Honorary Secretary	J.H. Gold
Executive Secretary	D.D. Peacocke

BRANCH SOCIETY REPRESENTATIVES

Antigonish-Guysborough	D.P. Cudmore
Bedford-Sackville	M.J. Fleming
Cape Breton	M.E. Lynk & D.P. Hickey
Colchester-East Hants	C.K. Bridge
Cumberland	R. McL. Washburn
Dartmouth	R.A. Oliver & W.R. Lee
Eastern Shore	D.P. Sinha
Halifax	I.A. Cameron, D.A. Gass & V.P. Audain
Inverness Victoria	G.W. Thomas
Lunenburg-Queens	G.H. Nickerson
Pictou	A.K. Clark
Shelburne	W.H. Blair
Sydney	P.F. Murphy & G.E. Boyd
Valley	J.R. MacEachern & R.R. Kimball
Western	P.L. Loveridge
Student Members	D. Campbell, G. Raymond & M. Conrod
I.R.A. Representatives	Allan Patrick & Dianne Mosher

OBSERVERS AND STAFF

Economics Committee Chairman	W.G. Acker
Manager, Economics Department	A.A. Schellinck
Director of Communications	

OBSERVERS

Editor-in-Chief — <i>The Nova Scotia Medical Bulletin</i>	J.F. O'Connor
Representative to Provincial Medical Board	G. McK. Saunders
Medical Director M.M.C. Inc.	H.J. Bland
General Manager M.M.C. Inc.	S.P. Brannan
C.M.A. Board of Directors	R.D. Saxon
C.M.A. Council on Health Care	D.S. Reid
C.M.A. Council on Economics	P.D. Muirhead
C.M.A. Council on Medical Education	J.D.A. Henshaw
M.D. Management Limited	G.A. Sapp

STANDING COMMITTEES

	Chairman
Allied Health Disciplines	A.H. Shears
Annual Meetings	President
Archives	E.F. Ross
Awards Committee	W.F. Mason
By-Laws	A.S. Dill
Cancer	A.J. Bodurtha
Child Health	G.H. Nickerson
Community Health	M. Kazimirski
Drug & Alcohol Abuse	J.P. Savage
Editorial	J.F. O'Connor
Ethics	K.R. Murray
Finance (Treasurer)	W.H. Lenco
Hospitals & Emergency Services	M.F. Moriarty
Legislation	K.R. Murray
Maternal & Perinatal Health	T.F. Baskett
Medical Education	G.J. Butler
Membership Services	K.R. Langille
Nutrition	C.N. Williams
Occupational & Rehabilitation	J.D. Prentice
Pharmacy	V.P. Audain
Physical Fitness	M.R. Banks
President's Committee	President
Salaried Physicians	D.R. MacLean
W.C.B. Liaison	

BRANCH SOCIETIES

	President	Secretary
Antigonish-Guysborough	P.J. McKenna	T.D. Smith
Bedford-Sackville	J.W. McNab	G.B. Mader
Cape Breton	B.J.M. O'Brien	J.A. Steeves
Colchester-East Hants	C.K. Bridge	R.L. Rondeau
Cumberland	M.F. Husain	K. Thakkar
Dartmouth	W.R. Lee	L.B. Marr
Eastern Shore	W.C. Brown	D.R. Barnard
Halifax	I.A. Cameron	S.B. Gibbon
Inverness Victoria	G.W. Thomas	K.R. Murray
Lunenburg-Queens	D.F. Large	F.G. Bell
Pictou	J.G. Forbes	C.S. Giffin
Shelburne	D.H. Wilson	M.E. Riley
Sydney	P.F. Murphy	W.A. Crooks
Valley	R.R. Kimball	W.N. Enright
Western	D.S. Armstrong	W.M. Gorman

SECTIONS

Anaesthesia	A.C. Walker	K.R. Hamilton
General Practice	M.J. Fleming	R.A. Oliver
Internal Medicine	L.P.M. Hefferman	B.J. Cookey
Internes & Residents	B. Wright	S. Robinson
Obstetrics and Gynaecology	C.A. Maley	S.C. MacLeod
Ophthalmology	J.H. Quigley	V.P. Audain
Orthopaedic Surgery	J.C. Hyndman	G.H. Reardon
Otolaryngology	J.D. McLean	F.S.H. Wong
Paediatrics	J.G. Gatién	R.S. Grant
Laboratory Medicine	A. Covert	A.J. Wort
Psychiatry	W. Junek	R. Morehouse
Radiology	J.A. Aquino	W.F. Barton
Surgery	J.O. McNeil	
Urology	S.G. Lannon	W.A. Ernst

NEW SOCIETY SERVICE FOR MEMBERS

DR. DONALD F. SMITH
Obstetrics and Gynecology

Suite 306-Medical Arts Bldg. Phone 423-7460
680 Spring Garden Rd.
Halifax, N.S. B3H 1Y1

For _____ Age (if under 16) _____

Address _____ Date _____ 19 _____

Label as to contents YES NO
Safety closure YES NO
Repeat Repeat X at _____ intervals
Product selection approved YES NO

Signature _____
Physician's License No _____

This form endorsed by The Medical, Pharmaceutical and Dental Societies of Nova Scotia.

For _____ Age (if under 16) _____

Address _____ Date _____ 19 _____

Label as to contents YES NO
Safety closure YES NO
No Repeat Repeat X at _____ intervals
Product selection approved YES NO

Signature _____
Physician's License No _____

This form endorsed by The Medical, Pharmaceutical and Dental Societies of Nova Scotia.

NEW LOW COST PRESCRIPTION FORMS STAND BY YOU AND YOUR PATIENTS

Please allow not less than 28 days for delivery of order.

UNIFORM PRESCRIPTION FORMS have been endorsed by The Nova Scotia Medical Society and the Nova Scotia Pharmaceutical Society. These forms provide space for all pertinent information and include safety features which inhibit alteration and even counterfeiting.

AVAILABLE NOW to Society members and Nova Scotia hospitals, the forms will be custom printed to include the required individual, group or hospital name(s), address and phone number(s).

ORDER carefully fill in the blank form in the top right hand corner with the necessary information as per the accompanying sample copy. Your name, quantity ordered and billing address should go on the form in the bottom right hand corner.

NOTE — Actual prescription forms are printed black on yellow background.

*LOW COST FORMS in pads of 100 each:

2,500 — \$ 37.74

5,000 — \$ 62.99

10,000 — \$101.73

*Prices include all taxes, shipping and associated charges

Effective October 1st, 1984

QUANTITY ORDERED

2,500 5,000 10,000

OVER 10,000 _____ forms. (Please advise me of costs)

NAME

ADDRESS

PHONE

CHEQUE/MONEY ORDER ENCLOSED

PLEASE BILL ME

HAVE YOU FILLED IN THE BLANK FORM CORRECTLY?

MAIL TO:

THE MEDICAL SOCIETY OF NOVA SCOTIA