

Nationalized Medicine: A Realistic Approach

SIR LIONEL WHITBY C.V.O., M.C.

Regius Professor of Physic, University of Cambridge
Past-President of the British Medical Association

(A communication to the Nova Scotia Medical Society.)

I WISH to make it clear at the outset that I am not here as an advocate of nationalized medicine, but my talk will present the problem to you from the academic standpoint and in the spirit of debate, giving what I think is a reasoned explanation of what has happened in Britain.

Winston Churchill once said "the further one looks back the more one can look forward", and so when controversies arise it is profitable to look back into history where one usually finds that very few problems are new. Nationalized Medicine in Britain began in 1948 A.D. One can go back as far as about 1948 B.C., in which year King Hammurabi, of Babylon, issued a code of medical practice which was published in every market place, and which laid down the conditions of practice, the rewards for good service and savage penalties for failure. We can be comforted that no modern government would require the surgeon's hands to be cut off when an operation is unsuccessful.

We are all familiar with the centrally regulated public health measures of the Jews, which were controlled by the priests, and peculiarly fitted to a nomadic tribe. We are all aware of the State hospitals and public health measures of the Romans and Greeks.

In England some measure of State provision began with the Poor Laws of Queen Elizabeth and, to skip the centuries and come to more modern times, we have seen the intervention of the State becoming more and more prominent during the whole of this century.

There were many public health measures in the later part of the 19th. century, but deliberate and well thought out State intervention first began with the Boer war—the first of the wars of this century.

To many the Boer war is a trival affair, but it revealed to statesmen the appalling state of health of those who volunteered for service. It was imperative to improve the general standard of physical fitness of the nation, in view of the growth in size of continental armies and the inevitability of a European war.

Hence the Boer war was followed by the introduction of a School Medical Service and Maternity and Child Welfare Services.

The Ministry of Health was born out of the second war in 1914-1918, with an extension of State Services for venereal disease, tuberculosis and many other branches of medicine.

On the outbreak of the 1939-45 struggle, the country was forced to establish an Emergency Medical Service which could be run only by the State. This has formed the pattern of the present service.

So much for the historical aspect, but what of other factors. What of the changing face of medicine?

New advances in medicine now come with such rapidity and new specialisms spring up with such speed that few in this generation appreciate that less than half century ago the practice of medicine was almost entirely em-

pirical. At the beginning of this century and for centuries before the practice of medicine could be conducted by individual great clinicians with no more equipment than their five senses, a few simple instruments and the wealth of their experience.

But now a clinical opinion is usually no more than an orientating contribution leading to the performance of a host of scientific procedures designed to confirm or refute the opinion. For example, it may cost £50. to find the cause of a pyrexia of unknown origin before it can be determined that it is not a public menace or is unsuitable for modern chemotherapy.

Likewise with therapeutics. Think of the primary cost of penicillin or streptomycin or Compound E, as compared with the simple and mainly ineffective remedies of the early part of the century. Were there not some subsidy, who is there who could afford them?

So also with surgery. The general surgeon is almost unknown whilst many specialists require their own not inconsiderable team, including special anaesthetists. One can guess that the cost of a thoracoplasty, from the time the patient enters hospital to the time of complete discharge, may amount to as much as £1000. Previously, such patients died. Now someone has to pay. But who?

The vast increase in the cost of medical diagnosis and treatment arises from the development of the scientific aspects of medicine based on discoveries of cause, of which our predecessors were ignorant. Cost is an increasing liability as medicine advances; it will never decline. In brief, the position is that because of these advances there are relatively few people who can afford to be ill with nothing more behind them than their own resources.

The general economic situation enters into this tangle. The increased cost of everyday living. The spiral of rising wages which, in the lower grades of society, never reaches a level sufficiently high to pay for medical treatment and in the higher grades is largely discounted by immense taxation.

In England the future evolution of the country was surveyed during the war in what is known as the Beveridge Report, which is aimed at devising measures for what is called Social Security, that is, security for all classes from want, unemployment, lack of medical attention and other hardships, down to such realistic but inescapable matters as the cost of being buried.. You should appreciate that during the war the whole British nation lived under conditions of great tension, never knowing, at least in the great cities, whether its homes would be intact from day to day, whether these homes would be actively invaded, and under such unpleasant conditions as black-out, strict rationing and long hours of work. The natural psychological reaction to such years of strain is a desire for security. This, rather than a trend to the left, is the explanation of Britain's social measures. The country has not gone Communist, and never will go.

It is important to realize that the Beveridge Report would have formed the basis of post-war policy in England whatever Government had been returned to power, though the interpretation and manner of implementation might have been greatly different according to the nature of the Government.

With these aspects in mind one is forced to conclude from the evidence of history, from the changes which have come over the face of medicine leading to a tremendous increase in the cost of medical treatment, from the vast increase in the cost of living and from the ideals expressed in the Beveridge Re-

port (whatever one's political views) that some form of subsidized medical service has come to be essential.

Anyone who does not acknowledge this is either not realistic or is unaware of the changes which have come over medicine or of the subtle evolution in civilized thought which has become sympathetic to the provision of efficient medical attention to all sections of the community.

In England the experiment is being made of providing these medical services by wholesale State control. To a large extent this policy has been forced upon the country because of the immense loss of manpower by the devastation of three wars, whereby it has become imperative for the State to intervene to ensure the preservation of the life and of the efficiency of every individual, rich and poor.

Whether it has been right to embark upon such an expensive programme at a time of economic stress, rather than on a wave of prosperity, is a political matter and outside the scope of my subject. I am merely discussing the subject from an academic aspect, my main point being that all civilized nations are sooner or later almost bound to adopt some form of subsidized medical service.

If this be acknowledged then what form shall subsidy take? Looking at history again we appreciate that in the 18th century the great voluntary hospitals were founded and endowed by rich, and sometimes pious, men and women to provide a medical service for the indigenous poor. This served for more than a century, and indeed, until wars disturbed economic values and until medicine had passed from the heyday of the great clinician to the stage which demanded an expensive team and expensive ancillaries.

The voluntary system began to totter about 1920 with the imposition of charges for admission according to income and with the development of the financial problems of the oppressed middle classes, the backbone of any country, in addition to the poor who are always with us.

The final blow to the voluntary system in England was in the 1939-45 war which called for, demanded, the creation of an Emergency Medical Service to meet the hazards of war, otherwise the hospital system of the country would have broken with the first air raids. The colossal cost of this E. M. S. could be borne by none but the State. Upon the experience of the E. M. S. the State Medical Service has been founded.

What are the alternative methods for subsidizing a medical service? By voluntary subscription, as of old, coupled with a charge where the income warrants a charge? I do not myself think this is practicable. Rockefellers and Nuffields will not be seen again, and the amount raised by these means will never again keep pace with the increasing cost of medical attention.

Can it be done by some form of private enterprise such as the Banks or the Insurance Companies realizing that many prudent people effect insurance against illness though the premiums are high. A voluntary scheme cannot cover the whole nation, whilst a compulsory scheme means the State, for only the State can exert compulsion.

And whoever controls the finance, whether it be the State or an insurance company, there is inevitably the exercising of control over expenditure and the host of regulations and mass of paper work which such control entails. Practical aspects really demand that the State must provide the money whether by a small-poll tax on all or the heavier taxation of those who can best afford

it. Such details must be left to financiers and to the customary procedures of the country concerned.

The vital matter is how much control is to be exercised by those who hold the purse strings and how much latitude and freedom can be left to the profession which hitherto has practiced medicine, not without credit, as, when and how it pleases. Our fundamental sentiments and whole instincts are opposed to bureaucratic control of an individualistic profession.

This matter of freedom from control has been one of the main items of contention in England where a complete and comprehensive service has been imposed by legislation.

Some of the details of the struggle are worth recalling.

The profession insisted on about six major points and showed, by a plebiscite, that unless these points were conceded they would not operate the service.

1. That in the public interest the terms of service should not lead directly or indirectly to the profession becoming full time salaried servants of the State. This, in effect, meant that all should have opportunity to continue private practice *in toto* or in part, as they wished. This point was gained to the extent of forcing the Government to introduce an amending bill in which it is decreed that a full time salaried service can only be imposed by new legislation and not by regulation. A Government cannot, of course, bind its successors, but a new Act means publicity and opportunity to oppose. It is, of course, voluntary to join the service but, in practice, most have joined the service on account of economic pressure and this is especially so among the young in contrast to those who have been established in practice for years.
2. That the profession should be free to exercise the art and science of medicine according to its traditions, standards and knowledge, the individual doctor retaining full responsibility for the care of the patient, freedom of judgement, action, speech and publication without interference with his professional work.
3. That the patient be free to choose his own doctor and to change his doctor and likewise the hospital in which he is treated. The patient also may decide whether he avails himself of free or private treatment.
4. That Doctors, like other "workers" must be free to choose the form, place and type of work without direction from the Government or other authority.
5. Every registered medical practitioner must be entitled as a right to take part in the service if he so wishes.
6. There must be adequate medical representation on all administrative bodies.

I may mention that the biggest struggle concerned the matter of a full time salaried service since this conflicted with Socialist principles and most will know that the first Act in Britain conflicted with some of these medical demands. The result of the plebiscite, however, led to the acceptance of most of them.

So much for control. Freedom must be preserved and bureaucratic domination avoided as much as is humanly possible.

An almost equally important matter is how much service should the controlling authority provide. Should it be a full service for all irrespective of means? Should it be a full service for some and a partial one for others? Should it be no more than hospital service for some or all? Should treatment or consultation be not entirely free, except for the penniless, so that all, or nearly all, must pay something even though it be no more than a few cents. This is always a healthy deterrent from the overuse of a free service. When all is free the public not only exercise their rights, they actually demand them. The lay press keeps the public informed—many would say, misinformed—about recent advances in medicine and the public is less critical of its knowledge than we are. When all is free they demand what they think is the latest treatment by right. The doctor may be in danger of legal action if he does not accede to the request.

Let me now make one or two points about the British Service and draw certain conclusions from this to enable others who find themselves forced to adopt a subsidized medical service to profit by the British experience.

1. The considered opinion of the profession in England is that if a State service is inevitable then the only equitable basis of remuneration for general practitioners is a capitation fee and for the hospital duties of a consultant by means of a sessional fee. There can be little doubt that the New Zealand system of fee for item of service is grossly extravagant and so readily open to abuse that even the normal honest man has his honesty taxed to the limit.
2. As was to be expected a number of difficulties, grievances and anomalies have arisen when a homogeneous procedure is imposed upon a heterogeneous community. For example, it is abundantly clear that the same method of payment cannot equitably be applied to the small capitation of a widely scattered country practice and the economically sufficiently capitation of a densely populated industrial area.
3. As was to be expected the institution of an entirely free service has shown up the deficiencies of hospital accommodation and of facilities, as well as lack of equipment and supplies of apparatus, material such as X-ray films and the more expensive drugs.
4. Nor do many of the pious hopes contained in the scheme, such as the establishment of health centres or central consulting rooms, seem likely to be more than pious hopes for one or two decades.
5. Furthermore the violent fluctuations in economic values make the worth of any fixed remuneration out of date almost from month to month.
6. A service of this kind is expensive and should depend upon what the country can afford. The cost in England was gravely underestimated. The cost of an entirely free service is fantastic. There is little doubt that the public overuse a free service and do not fully value anything which is entirely free.
7. Nevertheless, the service is working reasonably well and the profession is entering into the service in a good spirit, determined to do all in its power to make it a success. Doctors will endeavour above all things to preserve the humanity of medical practice and avoid regarding the patient as a number in a card-index or a mere vehicle of disease to which rules and regulations must be applied.

Assuming then that there has to be some form of subsidized medical service, what is to be learned from the British experiment.

There are many things, but I first remind you that the British have had a partial State service since 1911, with the National Insurance Act, and that this came to work quite well. I need hardly remind you that in this Continent there is also a vast experiment in progress from which much can be learned. I refer, of course, to the State subsidized Veterans' Service, which provides an experimental field of some 20 million people.

But these points can be learned from Britain:

1. Take matters slowly and not all at one mouthful. This was continuously advocated by the profession in England, but the politician swept the advice aside. We might have extended the National Insurance benefits to higher levels of income in various stages. You might have to examine your Veterans' Organization with a view to extension.
2. Put your hospital services in order first, so that they are adequate to cope with increased work bearing in mind that this involves not only beds but also nurses and domestic workers.
3. Make the service flexible, so that there is latitude to adapt it to widely differing communities—urban and rural—and still provide a reasonable living for all the profession.
4. Do not make the service absolutely free save upon certification of poverty. A few shillings for spectacles, a few pence for a bottle of medicine, a small charge for hospital maintenance are healthy deterrents from overuse.
5. Keep power out of the hands of lay administrators by demanding and taking an active share in all administrative problems and reduce paper work to the minimum.
6. Leave elbow room for the public to have private service if they so wish. This is an incentive to good work. Other incentives should also be available, such things as extra payment for clinical teaching.
7. Ensure that you have security of tenure and cannot be dismissed at short notice save for grave misdemeanour or gross neglect of duty.
8. See that you have appropriate machinery for the satisfactory settlement of disputes and grievances.

I am a dyed-in-the-wool Conservative of the old British school and all my instincts are opposed to nationalization and State control. I am also of that age and seniority and status which resents interference with the practice of my profession. Yet much of what I have said to you may appear to be socialistic. But I would remind you that my title was a realistic approach to nationalized medicine, and that is the way in which I wish you to regard my remarks. Conservatives are quite prepared to advance with the times and a British Conservative Government, with Churchill at its head, would undoubtedly have imposed some form of national medical service upon us. This because of the realism which I have outlined. If the same measures should be forced upon you because of economics, wars, plague or pestilence, may you learn something from our mistakes.

Bear in mind that a State Medical Service is a political weapon, a plank in a politician's platform, as well as a matter of intimate concern to the medical

profession. As a political issue the politician is more conscious of the hundred million votes of the populace than the opinion of a hundred thousand doctors. But the reasonable politician is open to suggestions from the profession as to how best to launch such a Service and how best to obtain the profession's co-operation. My final advice to you therefore is to think on these things, to give time and trouble to preparing your case so that you may present to the politician something constructive which is acceptable to yourselves, and, above all, to prepare your own propaganda machinery in order that your case may be fairly presented to a public which always thinks that the main arguments are about sordid questions of finance.

96th Annual Meeting of The Medical Society of Nova Scotia, 1949. Second Business Meeting

THE second business meeting of The Medical Society of Nova Scotia was held at White Point Beach Lodge, White Point Beach, N. S., Thursday, September 8, 1949, at 2.45 p.m.

President H. A. Fraser was in the chair.

The report of the Nominating Committee was first received and was as follows:

Place of 1950 meeting: Halifax.

President—Doctor E. F. Ross, Halifax.

First Vice-President—Doctor J. J. Carroll, Antigonish.

Second Vice-President—Doctor L. M. Morton, Yarmouth.

Treasurer—Doctor R. O. Jones, Halifax.

Secretary—Doctor H. G. Grant, Halifax.

Legislative Committee—Doctors A. E. Murray, C. L. MacMillan, and J. W. Reid.

Cancer Committee—Doctors S. R. Johnston, V. O. Mader, C. M. Harlow, and representatives of the Branch Societies Committees on Cancer.

Public Health Committee—Doctor J. S. Robertson and the Executive of the Nova Scotia Medical Health Officers' Association.

Historical Committee—Doctors A. L. Murphy, H. L. Scammell and J. A. Webster.

Workmen's Compensation Board Committee—Doctors W. K. House, J. R. Maeneil, R. A. MacLellan, E. F. Ross, A. E. Blackett.

Editorial Board Committee—Doctors Margaret E. B. Gosse, H. C. Still and W. E. Pollett.

Medical Museum Committee—Doctor E. P. Nonamaker and Secretaries of the Branch Societies.

Cogswell Library Committee—Doctors A. L. Murphy, H. D. O'Brien and D. J. Tanning.

Medical Economics Committee—Doctors H. D. O'Brien, H. A. Creighton and F. J. Hogg.

Pharmaceutical Committee—Doctors R. A. Moreash, A. L. Cunningham and H. R. Ross.

Industrial Medicine Committee—Doctors J. W. Merritt, J. G. B. Lynch and J. C. Wickwire.

Divisional Representative, Editorial Board of Canadian Medical Association—Dr. H. L. Scammell.

Membership Committee—Doctor H. G. Grant and Secretaries of the Branch Societies.

It was moved by Doctor Eric W. Macdonald that this report be adopted. Doctor W. A. Hewat moved that nominations cease, which was seconded and carried.

Doctor H. A. Fraser declared these officers as read elected. He stated one further committee, the Advisory Committee to the Government, which is not a standing committee, would have to be named at this meeting, which would be done following the reading of that report.

As the schedule of fees had not been completely finished with last night, it was moved by Doctor S. Marcus that a flat X-ray plate of the abdomen be \$5.00. This was seconded and carried.

Doctor H. W. Schwartz moved the adoption of the report of the schedule of fees as revised. This was seconded by Doctor J. J. Carroll and carried.

The Report of the Advisory Committee re Federal Health Grants, as published in the Executive Minutes, was read by Doctor N. H. Gosse.

Doctor G. B. Wiswell stated that these were very excellent reports that are read off and are quite long, and it is very difficult to remember them and get the whole picture, and he wondered if it would be possible to have copies for study.

Doctor W. A. Hewat moved that the reports of all committees be published a month before in the Bulletin so that members could be prepared to discuss them when they came to a meeting. This was seconded by Doctor J. W. Reid.

Doctor N. H. Gosse: "It has been customary to have reports printed in the Bulletin for a permanent record. They could be put forth in booklet form first. The problem is that reports are not in until the last few days. I move that all reports which would come before a meeting be published in booklet form and issued in time so that they can be studied by each member of the Society before the meeting." This was seconded and carried.

Interim Report of the Sub-Committee on Cancer Control— The Medical Society of Nova Scotia

To the Honourable L. D. Currie
Minister of Health for Nova Scotia
Halifax

Sir:

The sub-committee on Cancer Control of The Medical Society of Nova Scotia set up under the direction of your advisory committee on the Health Grants, would now beg leave to submit the following result of its studies and deliberations. It would request that it be regarded as an interim report, for reasons which the report itself will more fully indicate.

Cancer as a cause of death

Cancer as a cause of death ranks second, among us, and it is twice as great as was tuberculosis in Nova Scotia by 1946 figures. Unfortunately, it is probable that such figures are low for Cancer, for many deaths due to Cancer are reported in error as being due to the terminal cause rather than the basic or primary cause.

Prevalence of Cancer

Another figure which adds greatly to the importance of this phase of the matter is the number of persons still alive though suffering in various stages of this disease. It is difficult to estimate the number of such persons. The proportion of those alive to those who are dead is variously stated by those who have made studies of the figures, as from 3 to 1 to 15 to 1. The truth probably lies somewhere between those figures, but no means are available for the accurate determination of this ratio. Such means should be provided, for details of plans for long-time control of this disease must be based upon them.

Cancer should be reportable

To this end, *Cancer should be a reportable disease*, and a central registry should be established to receive such reports as soon as a diagnosis is made.

The study that has been given to the broad question of Cancer of late, both by National and Provincial or State bodies, recognizes three major phases in the development of any over-all programme for the Control of Cancer, and in the amelioration of the lot of the Cancer patient:

Three phases in Cancer control

- (1) Spread of knowledge concerning Cancer;
- (2) The development of personnel and facilities for early diagnosis and treatment;
- (3) Continued care of the Cancer sufferer,
 - (a) until cured, but perhaps more importantly
 - (b) until he or she dies.

Need for wide knowledge of early signs

The insidious nature of Cancer demands knowledge of its earliest signs or symptoms on the part of our people, before they will be brought to report such early signs to the family doctor, or, in the case of the less fortunate, to a public clinic.

Need for special skills in diagnosis

Statistics indicate that about 90% of those who die of Cancer have their primary growth in the internal body organs—in regions in which assessment of symptoms is difficult on the part of physicians, and in which, frequently, special skills are required, both to diagnose the condition accurately, and to treat it successfully.

But once Cancer is suspected, there should be available to both physician and patient, such special diagnostic and therapeutic facilities and skills as are possible to acquire or to develop, not only so that the Cancer may be eradicated or controlled, but also so that those who with certain symptoms for fear that they have Cancer may by such investigation and the elimination of such probability, have their fears allayed.

First Phase—Public Information

Public education and the Canadian Cancer Society

The Profession of Medicine in Canada recognizes that the provincial divisions of the Canadian Cancer Society have been valuable agents in the

education of our people. This is becoming more widely recognized across Canada at both national and provincial levels.

In this connection it is noted with pleasure that that Society is breaking away from the note of fear, that has characterized much of the Cancer publicity of this continent, and its psychological approach to the problem is employing a note of encouragement and greater hope.

It is now well recognized that the services rendered in this field of public education are very valuable, and that therefore the division of that Society in Nova Scotia should be encouraged to develop and extend its work until every community is covered by its effort.

Public education vs. professional education and facilities

It must be recognized however, that the good of this important phase in Cancer Control is wasted if it extends itself beyond the development of the second phase, i.e. if trained personnel and the requisite facilities and means of detection, skilled diagnosis and proper treatment have not kept abreast of public education.

II—Second Phase—Diagnosis and Treatment

The most urgent needs under this head, at the moment, are:

- (a) Expansion of measures for the making of early diagnosis.
- (b) The provision of facilities for the prompt and efficient treatment of Cancer.

Need of active hospital beds for cancer patients

Under the second of these it should be pointed out that at the moment in this province there are no beds specifically allotted to the care of Cancer patients. Our hospitals throughout the province have been hard-pressed for years to take care of the patients that seek admission, yet they have been receiving as many Cancer patients as they can and as early as they can having regard to the urgent needs of persons with non-malignant illnesses. But many a doctor—probably most doctors in Nova Scotia—while recognizing the good intention of those directing admissions in our hospitals, express the view that the time which must still elapse between the time of his making application for the admission of his Cancer patient, and the time of the actual reception of such patient, is much too long if any system of Cancer Control is to be even effective.

Improving the Diagnosis of Cancer

Professional education

This sub-committee subscribes to the view that the general practitioner in the field is our first line of defence against this enemy and that therefore anything that can be done to develop his knowledge of Cancer diagnosis, or to otherwise assist or encourage him, should be supported adequately. It believes that this should begin in the days of undergraduate course in Medicine and that the significance of his place in our system of Cancer Control should be indoctrinated there by greater correlation of the teaching efforts of Cancer as a subject. It believes that a special department be set up in the Medical School to effect this, and that such department in conjunction with the Principal Cancer Centre shall continue to maintain contact with such

students long after they have left to practise in this province. It believes that funds should be provided and arrangements made with the Medical School for the setting up of such a department and for the direction and development of this work, for it is felt that the teaching of Cancer must attain something of the importance of the teaching of tuberculosis as it is presently seen in the Medical School before any comparable interest in early diagnosis will become apparent.

Support for special training in Cancer is important

This sub-committee would express the view that a very important measure in advancing the quality of diagnosis and treatment of Cancer would be the training of additional professional personnel; that effort should be made to induce men to take up such studies and training and that funds should be made available for the financing of same.

Tissue and smear examinations

In so far as possible the presently existing facilities for the pathological examination of tissue specimens, smears, etc., should be supported and extended and provision made for the attendant registration of all proven cases of Cancer.

Applying improved facilities and skills to the people

It is visualized that the benefits of the improved facilities and skills would reach the public in several ways:

(a) Through *Cancer detection and Consultation Clinics* set up in different parts of the province, to which patients may be referred and at which they may receive certain diagnostic examinations and consultations and be advised as to their treatment.

(b) Through the establishing of a *Principal Diagnostic and Treatment Centre in Halifax*, in or about the Victoria General Hospital, adequately staffed and equipped and which, in addition to the facilities for both undergraduate and post-graduate teaching of Cancer through the correlating department of the Dalhousie Medical School, and which will be dealt with more specifically below.

It is felt that such a Centre might well, through its director, provide, for assistance in the setting up of regional detection clinics, for the development of facilities for professional education in Cancer diagnosis, and generally to take responsibility for the study of all phases of Cancer diagnosis and treatment and for the making of recommendations to the government with respect to the application of the most modern methods in Cancer Control.

(c) Through the provision of a substantial number of hospital beds for the active and early treatment of Cancer patients, and

(d) Through the provision of other hospital or other institutional beds to relieve the active beds and generally to provide for:

I. Convalescent patients, and

II. For those patients who cannot be given proper care at home, especially terminal cases.

Research

This Committee, on behalf of The Medical Society of Nova Scotia would express the view that research into the cause or causes of Cancer and into the improvement of methods for its care and control should have generous and active support.

III—Third Phase—After Care and Follow-up

Care of the convalescent and of the incurable—Social service

This phase may better be described under the head of "Welfare." Here again the Nova Scotia Division of the Canadian Cancer Society is already making a substantial contribution—a Free Cancer Dressing Service, the loan or other provision of a variety of things which make for the patient's comfort at home, and other worth-while services. It is our understanding that they have been giving consideration to the employing of a trained Social Service worker to head up a programme of development of this work throughout the provincial units of the Society. In this is indicated their belief that there is need for the development of this phase of Cancer work. It is our view that it should be very greatly developed and extended—certainly to the limit of their resources.

It is hoped that co-operation and consultation as between the Health Units of the Ministry of Health and other visiting nurses and Social Service workers, and the Cancer Society may assist the Society in the follow-up of patients, and in extension of its present services, so that suffering from Cancer may be further alleviated.

Interest of the medical profession

Recognition of place of the Canadian Cancer Society

The Medical Society of Nova Scotia, while concerned in all three of the phases here suggested and outlined, may be said to have its immediate interest in the second phase. We believe however, that in the case of phases 1 and 3, the Government in its overall interest in the problem of Cancer Control in this province might do well to recognize the Canadian Cancer Society as the body to develop those aspects of the problem and give advice to that Society as to the items which it might consider the Society should promote, so as to avoid duplication of effort. By such recognition it would commend its activities to the charity of our citizens, upon which its activity depends, and it would confirm on the provincial plan action that has already been taken by the Minister of National Health on the national plan.

Specific Recommendations

Our specific recommendations must be divided into two parts:

Part I—For Immediate Approval and Action

(1) That Cancer be made a "reportable" disease—that is to say, that all malignant tumors shall be registered as soon as possible after the diagnosis is made. The purposes of this recommendation are:

- (a) To determine the morbidity of Cancer in our province;
- (b) To provide information prerequisite to any long range development of measures for control, and to the determining of necessary facilities of treatment and continued care;

- (c) To assist the physician in the care of the patient; and
- (d) So that an effective follow-up system may be instituted in the best interest of the cancer sufferer.

Provincial Clinics

(2) That there be set up throughout this province Cancer Detection and Consultation Clinics to which patients may be referred and at which they may receive certain diagnostic examinations and consultations and be advised as to their treatment.

The cost of operating such centres or clinics would be at the cost of the fund and not at the cost of the patient. Such Detection and Consultation clinics might well have their headquarters in hospitals except where such an arrangement would be prejudicial to the work and objects of the clinic.

Biopsy service: need for a statement

(3) That the biopsy service of this province including smears, be extended, but that consultations be held, with our pathologists, and a statement issued for the guidance of physicians on the subject of the biopsy—its principle uses and dangers.

Diagnostic and treatment centre in Halifax

- (d) That to initiate the service in Cancer Control there be established at the Victoria General Hospital in Halifax a Principal Diagnostic and Treatment Centre, fully equipped and manned for dealing with cases requiring highly specialized skills and techniques in the diagnosis and treatment of Cancer; that while in its organization personnel may be drawn from the Victoria General Hospital and laboratory staffs, as soon as practicable respect be shown for the principle of specialization in Cancer therapy and that specially trained personnel be added for such specialties as they become available: And it is recommended, that in addition to its ordinary function suggested herein, it shall provide for:

Widespread Professional Education

A. Close affiliation with the Medical School of Dalhousie University, to the end, that in such affiliation, provision shall be made for the correlation and extension of professional education in this subject in the fields of both under-graduate and post-graduate teaching, and that such post-graduate teaching shall provide:

- (a) for the training of men to higher qualification for service in either regional clinics or in Principal Centres as may be required,
- (b) for short courses for groups of general practitioners or others in the methods of the early discovery of Cancer and
- (c) for adequate space for special Cancer teaching, whether didactic or by demonstration, and
- (d) for such University Extension lecture service as may be practicable.

Research

B. Provision for clinical research.

Special Professional Training

(5) That the "Professional Training Grant" be employed for the training of needed personnel in the various medical, surgical, radiological, pathological, and biophysical special fields, relative to the diagnosis and treatment of Cancer. (There is an immediate need and a future need for trained personnel far in excess of the supply.)

Director of the Principal Centre Director of Cancer Control

(6) That, for the proper carrying out of all these recommendations, a director be appointed of experience and ability who would be qualified not only to organize and direct the Centre, but who would be available for assisting in the organizing of the work throughout the province. In the arrangement between the University and the Government it would be desirable for such appointed to be acceptable to the University, for obviously such an office could well have added to it that of Correlator of Cancer teaching, or such other related office as the University, by arrangement, might create. This would be in keeping with the best practice elsewhere on this continent.

Hospital beds for Cancer patients

(7) Beds. That there be beds, specially allocated and set aside for the diagnosis and treatment of Cancer patients, together with necessary special facilities for their care. It is recognized that this may well involve the employment of buildings already in use, but there should be kept in mind the erection of a new building intended and used for the hospital care of active Cancer cases.

Other Personnel

(8) That provision be made for the appointment of such personnel as may be required for the proper functioning of the Centre.

Part II—For Study and Deferred Recommendation

The extent to which services other than Diagnostic Service may be without cost to the patient:

It is assumed that for practical purposes "the garment must here be cut according to the cloth"—that no greater amount of service can be given than that for which funds have been provided; and as there is reasonable doubt that the total sum available will extend to a complete cancer service, it is proposed that a study be made of the cost of services over recent years with a view to arriving at what the probable cost of such services would be if now offered at the expense of the State, (a) universally or (b) to those who could not support the cost of same. In this would enter:

(a) Cost of transportation.

(b) Cost of hospitalization.

(c) Cost of professional services.

(d) Depending upon whether wide or restricted application is considered. Number below the selected income level.

If on the compiling of such data it were found that any one or any two of them, in addition to the items recommended under Part I, amounted to

more than the sum available under the grant then consideration would have to be given to priority, and other measures would have to be employed—such as the charitable work of the Cancer Society before mentioned for the care of those unable to provide for themselves the service so excluded.

It will be apparent therefore that specific recommendations under this Part should await the results of the studies to be made. We would beg leave therefore to present this interim report now, and to follow with the second part as soon as the possession of requisite information will admit of its being intelligently formulated.

Members of the Sub-committee on Cancer:

H. R. Corbett

Norman H. Gosse, Chairman

J. C. Wickwire

E. W. Macdonald

Approved by the Advisory Committee of The Medical Society of Nova Scotia:

D. F. Macdonald, Yarmouth

A. E. Blackett, New Glasgow

H. G. Grant, Halifax

M. J. Macaulay, Sydney

J. P. McGrath, Kentville

H. D. O'Brien, Halifax

J. W. Reid, Halifax

H. A. Fraser (ex officio), Bridgewater

Norman H. Gosse, Chairman

Doctor V. O. Mader: "As the outgoing chairman of the Cancer Committee Doctor Gosse very kindly sent me a copy of this report, and I read it very carefully, and I would now pass it on to the incoming President of the Cancer Committee. I think that it is far too long, and that it might be briefed. I think it is a pretty heavy piece of material for a Government or Minister to digest."

The following letter was read by Doctor N. H. Gosse.

Halifax, March 18, 1949

Norman H. Gosse, M.D.
240 Spring Garden Road
Halifax, N. S.

Dear Dr. Gosse:

I have received your report as Chairman of the sub-committee on Cancer Control. To a layman like myself I found it to be well prepared, comprehensive, moderate and convincing.

The comments from the officials of the Department of Health are that it is an excellent interim report on the serious and important problem of cancer.

I realize that the final report cannot be prepared for some time and it may be that a meeting should be held between myself and your committee to see whether we could explore the requirements for equipment and personnel which would be needed for a centrally controlled programme and for the teaching and treatment which might be thought to be necessary adjuncts to any principal therapeutic and diagnostic centre that might at some time be organized.

Thank you again for the thorough manner in which the subject has been approached and for the time you are devoting to this effort.

Yours very truly

(Sgd.) L. D. Currie

Minister of Health

Doctor H. G. Grant said he would like to congratulate Doctor Gosse on his report which represented a lot of study and hard work, but he would like to differ materially with the comment that the Medical School of Dalhousie should create a department for the teaching of general cancer. The Medical School does not feel that they should have a separate department to teach cancer, but they would consider seriously the appointment of a correlator whose business would be to make a thorough study of the teaching as it now prevails, and to improve the teaching of cancer from the first year through to the final year.

Interim Report of Sub-Committee of The Medical Society of Nova Scotia on Tuberculosis Control (Federal Grants), August, 1949

Sub-committee: Doctors H. E. Kelley, Middleton
W. A. Hewat, Lunenburg
F. J. Barton, New Waterford
G. R. Forbes, Kentville
C. J. W. Beckwith, Halifax, Chairman

The sub-committee on the Federal Tuberculosis Grant of The Medical Society of Nova Scotia desires to submit the following report.

The sub-committee recognizes the following natural characteristics of the disease tuberculosis.

- (a) It is a communicable disease, caused by the mycobacterium tuberculosis.
- (b) It affects man in only two forms, the pulmonary and the extra-pulmonary.
- (c) As it is a communicable disease, it is a preventable disease and all aspects of control and treatment must, of necessity, have prevention as their primary objective.

The sub-committee desires to record its appreciation of the Federal Grant of Nova Scotia which amounts to \$182,585 yearly, recognizing that this, together with provincial government finances and those of voluntary agencies will substantially assist in advancing toward the control of this disease.

Recognizing that the Federal Grant is designed for the purpose of "assisting the provinces in an accelerated and intensified effort toward the eradication of tuberculosis and to extend progressively the provision of free treatment," your committee has decided that its duty is to study the tuberculosis problem and make suggestions relative to its control, immediate and ultimate without primary regard to the actual amount of the Federal Grant, but rather to strive toward further control in which the Federal Grant would provide important financial assistance.

In studying the Federal Grant itself it is to be noted that the Tuberculosis Control Grant is not a cumulative grant; that is the grant for 1948 to 1949 had to be expended prior to March 31, 1949, and that for 1949 to 1950 prior to March 31, 1950. The 1948-49 grant had been committed to new projects and at the time of inquiry we have found that the amount for the subsequent year has also been committed.

The expenditures were as follows (1948-1949):

X-ray Equipment—V. G. Hospital.....	\$10,141.12
Teaching nurses, etc., T. B. Control at N. S. Sanatorium.....	5,652.25
Cardioscribe for N. S. Sanatorium.....	900.00
Extension Rehabilitation Division at N. S. Sanatorium.....	6 75.60
Mobile Chest X-ray Unit.....	30,000.00
Travelling Surgical Team.....	6,000.00
Improvement Operating Room Lighting, N. S. Sanatorium.....	275.00
Structural Improvements, St. Martha's Hospital, Antigonish.....	1,216.24
Streptomycin.....	33,000.00
Improvement of Services in Sanatoria.....	6,800.00
Point Edward Hospital—Equipment.....	41,496.11
Point Edward Hospital—Operation and Maintenance.....	41,785.08
	\$177,941.48

In addition to this finding, we have knowledge of some very important research into the general public health, the results of which will undoubtedly influence your committee's final recommendations.

We therefore request that the report of this sub-committee be regarded as an interim report to be supplemented by a further detailed report when such details as are desirable become available.

Background

It has been customary to gauge the tuberculosis situation by two standards:

1. The total deaths from all forms of tuberculosis, expressed in rates is the number of deaths per 100,000 of population.
2. The number of available beds for sanatoria treatment per annual death.

Attached herewith are tables showing the tuberculosis death statistics for the interval 1921 to 1948 inclusive. The following points are worthy of note.

- (a) In 1921, with a population of approximately 524,000 there were 702 deaths from all forms of tuberculosis or a rate of 134.0 per 100,000 whereas in 1948 with a population of 635,000 (increase 111,000) the deaths from all forms had decreased to 239 with a rate of approximately 38.*
- (b) In 1921, the approximate number of beds for treatment was 300 or 0.4 beds per death whereas in 1948 there are 1,238 beds or approximately 5 beds per death. It is to be further noted that this calculation is based on deaths from all forms of tuberculosis, not pulmonary deaths alone.

These figures are quoted for the following reasons:

- (1) to indicate a reduction of 55% in deaths in an interval of 27 years.
- (2) to indicate that the plan for tuberculosis control has been reasonably efficient. It reflects credit not only on the organizations that have headed the control programme, but also on the medical profession which has been so co-operative and a co-operative public whom both seek to serve.

*Approximate figures.

- (3) Deaths from tuberculosis is a cold impersonal calculation. The tuberculous dead are the end result of a usually chronic disease, occupying years in its development from infection to disease to death. The number of deaths or death rate in no way portrays the needless suffering, the loss of time from active life and the disruption of family life or personal plans caused by the disease itself and which a well functioning control programme will prevent. The marked reduction in deaths is a fait accompli—submissible to further reduction, not alone through treatment but rather through an ever expanding plan of pure prevention, including early diagnosis prior to the sufferer becoming infectious through a positive sputum or discharges.

The recommendations incorporated in this report are classified under the following headings.

1. Case finding.
2. Prevention.
3. Treatment.
4. Rehabilitation.
5. Education.
6. Personnel Problems.
7. Welfare.
8. Voluntary Agencies.

In submitting a comprehensive plan for the future of tuberculosis control, we propose to start with case finding, probably the most dependable wedge to drive into the problem confronting us.

The basis of case finding is the acknowledged fact that *early* pulmonary tuberculosis of the re-infection type (known as Adult Tb. in the past) does not produce subjective symptomatology in the patient nor objective physical signs to the physician. Primary tuberculosis (known as Childhood Tb. in the past) may develop and run its course without recognizable symptomatology or physical signs. These two facts are so commonly observed that it means relative disaster for the patient to wait for symptomatology and then report to the physician.

Modern methods of diagnosis provide a practical solution to the problem in the practical use of radiography.

The first recommendation of your committee is that radiography be expanded in every practical manner to discover pathological pulmonary conditions in the population in excess of 12 years of age.

The implementation of this recommendation will require:

- (1) Extension of the use of "fixed X-ray units" in hospitals to cover selected groups in their communities with the employment of large 14" x 17" films.
- (2) Extension of miniature radiography by introducing the necessary apparatus in hospitals where circumstances of population and hospital admissions indicate.
- (3) Extension of miniature radiography in mobile units.

The Province of Nova Scotia has within its boundaries four miniature radiography units—

- (1) a portable unit serving the urban areas of Cape Breton County.
- (2) a fixed unit in the Halifax Tuberculosis Hospital.
- (3) a mobile unit purchased by the Nova Scotia Tuberculosis Association and the Provincial Department of Health but maintained by the Department of Health.
- (4) a fixed unit at the Victoria General Hospital primarily for the purpose of miniature radiography of all admissions, public and private, in-patient and out-patient as well as the hospital personnel.

The further extension of chest radiography and additional equipment required for miniature radiography, whether fixed or mobile, will require detailed study of local situations, hospital admissions and incidence of tuberculosis.

Recommendation No 2

Your sub-committee recommends that adequate diagnostic services be available to study and diagnose such pathology as may be discovered by radiography of the chest.

Explanation—The ever-expanding use of radiography of the chest has disclosed much pulmonary disease which may or may not be tuberculous. Each patient so discovered must be cleared as to whether the disease is tuberculous or non-tuberculous. If tuberculous, study is required to determine whether the disease is active or inactive, whether bacillary or non-bacillary, whether observation of treatment is required or whether the person can continue with his usual life. In fairness to the individual and because of ever-increasing trend to radiological discovery of earlier changes from normal, the clinical evaluation is ever more important.

Up to the present, the medical profession has leaned heavily on the Divisional Medical Health Officers to assist in such differential diagnosis. The introduction of miniature radiography, making possible up to 400 radiographs a day, of which 4 or 5% will require follow-up for adequate diagnosis, will add such a volume of this work that the load may well become too much and individuals lose the benefit of an early, adequate diagnosis of discovered pathological shadows.

Specifically, then, it is recommended that a diagnostic team work in conjunction with the mobile X-ray unit already functioning for the purpose of adequately diagnosing pathological pulmonary shadows and to advise concerning the best handling of the patient. If this proves to be successful, then the principle should be adopted for further development. As has been the practice, the family physician named by the patient will be notified of the conclusions and recommendations.

To be included under case finding is the necessity of adequate "clinic service" for the purpose of follow-up of known cases, contacts, etc. Even the development of miniature radiography to its full potential will not relieve this necessity. The practice has been for the seven Divisional Medical Health Officers to hold travelling clinics throughout their districts twice a year with regular clinics at each headquarters. This invaluable service will probably have to be extended to meet the demands of the expanding case finding programme.

While these additional factors will greatly enhance the case finding programme, leading to earlier diagnosis and lessened infectivity, the sub-committee recognizes the most valuable case-finding agency is the co-operative family physician, who, recognizing the marked limitations of physical examination, and the ever present possibility of tuberculosis, refers his patients for X-ray of the chest.

Your committee therefore recommends that any plan for extension of X-ray facilities for the lungs must provide free access to the practising physician and that The Medical Society of Nova Scotia adopt as a principle of practice that all adults reporting to his office have an X-ray of the chest, most particularly those patients with respiratory symptoms and expectant mothers.

By the same token, it is recommended that X-ray of the chest of all admissions over the age of twelve to hospitals be put into practise as soon as it is practical and that all hospital personnel and personnel having to do with other institutions should be X-rayed at the time of employment.

It is recommended that any case of tuberculosis diagnosed within or outside a hospital be reported to the responsible authority in that particular area so that the necessary follow-up of the family and other contacts may be expedited and the morbidity statistics on tuberculosis be maintained accurately.

Prevention

The finding of a patient with tuberculosis, from any source, immediately poses two problems. The epidemiological investigation in every instance and the matter of treatment for the patient, if indicated. Each is of equal urgency in the control of tuberculosis.

The epidemiological investigation is required on the basis of communicability of the disease. The family is the natural unit for investigation and is usually co-operative and desirous of such investigation, contrary to some opinions. All adults over the age of twelve should be X-rayed and tuberculin tested, the juniors tuberculin tested and, if positive, X-rayed or fluoroscoped.

The practice of X-raying contacts has been employed for some time. The time has now arrived when the tuberculin test is a most important item. The basis for this is that due to decreasing infection at large, there is an increasing number of negative tuberculin reactors in the youth and young adult group. This means that the chances of developing primary tuberculosis in the youth or young and even the adult group, are increasing year by year. As the prognosis and treatment for primary tuberculosis is quite different to that of the reinfection type, the knowledge of the tuberculin status from time to time is very important.

Your committee therefore recommends that tuberculin testing be incorporated as a routine procedure for selected groups, specifically known contacts, nurses, medical students, hospitals and institutional personnel. In due course, children in school and particularly high school students should be done.

It has now been amply proven from many sources that the positive tuberculin reactor is in a relatively better position with reference to defences against

tuberculosis than the negative tuberculin reactor. It is most desirable, however, that the organism creating the infection leading to a positive tuberculin should be innocuous and of known dosage. A positive tuberculin can be so developed through the use of B.C.G. vaccine.

Your sub-committee recommends that B.C.G. vaccine be employed in selected groups of negative tuberculin reactors specifically, known contacts of tuberculosis, medical students, nurses (graduate and under-graduate), personnel of institutions and hospitals having to do with the sick.

For several reasons we consider the time has not arrived to approach the problem of the whole negative tuberculin reacting population.

Treatment

Recommendations relative to treatment have to include several considerations.

A most important item is that sanatorium treatment should be free for the individual affected. Free treatment for the patient with pulmonary tuberculosis requiring sanatorium* treatment has been operative in Nova Scotia since July, 1946. In one community, the City of Halifax, the taxpayers pay the difference between a per diem government grant and the actual cost.

Your committee recommends that the hospital treatment of other than pulmonary tuberculosis should be free to the individual, for tuberculosis of the extra-pulmonary type is very frequently a local manifestation of a systemic disease, in which other foci sooner or later develop.

When this principle is adopted a serious study of extra-pulmonary tuberculosis morbidity would have to be undertaken and considered in relation to the sanatorium bed situation. In the meantime however, the principle could be applied to patients with these conditions who are presently in general hospitals and who will be admitted to general hospitals.

Beds

The bed situation, statistically speaking, for the treatment of pulmonary tuberculosis is very satisfactory, there being 5.2 beds per annual death in 1948. As it is planned to construct another 200 beds at the Nova Scotia Sanatorium this will mean 6.0 beds per annual death. Even with this apparently satisfactory situation, waiting lists for patients requiring sanatorium treatment is a constant factor.

The contradictory situation requires critical analysis and a special study is required to ascertain:

- (1) What is the situation with reference to adequacy of treatment (medical and surgical).
- (2) What number of beds will require replacement as a result of depreciation and/or safety.
- (3) The number of deaths from tuberculosis has shown a decidedly satisfactory trend and there would appear to be a danger of overbuilding.
- (4) The case finding programme in addition to bringing to attention many cases of early tuberculosis will also lead to the diagnosis of advanced chronic, more or less stabilized cases over the age of fifty who will require treatment and segregation for long periods of time.

*The term "sanatorium" includes tuberculosis hospitals.

Your committee therefore recommends a special study with reference to long term planning which will have as its objectives:

- (a) Determination of the best use of present sanatorium beds in the light of modern methods of diagnosis and treatment.
- (b) A special study in reference to "maximum benefit" patients (stabilized chronics with sputum positive for tubercle bacilli) with the objective of placing them in surroundings suitable to their condition and which would include occupational habilitation. It is within the realm of possibility that such an institution or colony could be at least partially self supporting. There is no doubt that such an institution would release a considerable number of sanatorium beds for active treatment and at the same time solve one of the most difficult problems of sanatorium administration. The situation in the field would be explored at the same time as there must be many patients under this classification. (Scheme to be voluntary).
- (c) The quicker turnover of patients diagnosed as infectious tuberculosis in general hospitals.

It would seem that such a study could be a legitimate charge against the public health grant and new beds and special institution for "maximum benefits" could be chargeable against the hospital construction grant.

Treatment

We note with interest and gratification that streptomycin has been made available without charge for the treatment of tuberculosis and paid for from the Federal Grant.

Your committee however, wishes to emphasize that the indiscriminate or ill-advised use of streptomycin is a very real danger to the patient, and would request that it be used in cases of tuberculosis only after adequate consultation.

Your committee recommends that any drug or anti-biotic discovered in the future, having been shown to be of practical use in treatment, should be supplied free of charge for patients with tuberculosis of any type after adequate consultation.

Surgery. Major thoracic surgery involves specialized knowledge, medical including bronchoscopy, surgical and anaesthesia. In considering extension of availability of thoracic surgery for pulmonary tuberculosis, the committee recommends that it be carried out in selected centres only and that facilities be developed to the point of adequacy in such centres.

Minor thoracic surgery can be done in any of the sanatoria provided the necessary equipment is available and personnel trained. It is with interest and approval that we note the development of a surgical team which will adequately provide for immediate demands, but it would seem advisable to have a staff member of the larger provincial hospitals trained in these procedures thereby releasing time of the team trained in major procedures for continued activities at their own surgical centre.

Rehabilitation

The theory of rehabilitation is to re-educate or to direct the training of a patient so that at the time of his or her discharge and thereafter, he will be in a better position to accept responsibilities in his community within the

physical limitations which may have been imposed by his disease. In practice, it does more for the patient while on treatment, for as soon as he is permitted, he is occupied in some way for limited periods having to do with the particular educational programme designed for him by the rehabilitation staff in consultation with the medical staff. It is anticipated that considerable assistance can be given in placing patients suitable for particular occupations.

Such a programme has been started by the Nova Scotia Tuberculosis Association with the approval of the Department of Health. A Director of Rehabilitation for the province has been appointed and is at present studying the requirements in the various sanatoria and tuberculosis hospitals.

The plan holds real prospects for helping to solve many problems to do with the tuberculous but will require staff and equipment for its materialization. There are definite merits in having the direction of this programme under a voluntary agency but the equipment is a legitimate claim on the Federal Grant.

Your committee recommends that the plan of rehabilitation for the tuberculous be developed to its greatest potential.

Post-Graduate Medical Courses

The contribution of the general practitioner to tuberculosis control has been very great. The advancing knowledge concerning treatment and prevention of the disease has necessarily centralized the specialized knowledge of these matters. As mentioned previously however, the most efficient case-finding agency is the practising physician and there is no doubt of his undisputed ability to do more in case-finding, adequate advice and better understanding of the patient after leaving the place of active treatment.

In recognition of these facts, and the combined active interest of physicians in the control of tuberculosis, your committee recommends that regular post-graduate courses be instituted for the purpose of refreshing and expanding the practical knowledge of tuberculosis.

Education

This item is placed before personnel because the personnel problem is intricably bound up with an inordinate and unnecessary fear of tuberculosis treatment in sanatoria. It is beginning to be solved insofar as:

- (1) The Halifax nursing training schools except the Victoria General Hospital have affiliation for training nurses at the Halifax Tuberculosis Hospital under a capable instructress.
- (2) The Nova Scotia Sanatorium offers an affiliation course for undergraduate and post-graduate nurses.
- (3) The Medical School at Dalhousie University has a course of instruction which should provide each medical student with a working knowledge of pulmonary tuberculosis.
- (4) The Halifax Tuberculosis Hospital and Nova Scotia Sanatorium are approved by the Royal College of Surgeons for one year's training leading to certification or Fellowship in Internal Medicine.
- (5) The use of B.C.G. in negative tuberculin reactors reduces materially the hazard of clinical tuberculosis in personnel of sanatoria and general hospitals.

It is recommended that arrangements be completed for an affiliation course in tuberculosis of each nursing school in the province and that all medical students show by examination that they understand the principles of diagnosis and prevention.

Personnel

Clinical Nursing—There appears to be no adequate immediate solution to the chronic shortage of graduate nurses for sanatoria. The initiation of a course leading to recognition of an individual as nursing aides in tuberculosis at the Nova Scotia Sanatorium is an endeavour to meet this situation for the present, but it is doubtful if it will solve it ultimately on its own merits.

It is recommended that consultations be held with the representative of the Registered Nurses' Association on the Health Survey Advisory Committee to explore methods of improving the situation.

Public Health Nursing—There is no doubt that the most efficient education and the most efficient individual in the prevention of tuberculosis is the public health nurse.

Your committee heartily endorses the principle of tuberculosis public health nursing being part of the general public health nursing programme, but also recommends that this service be extended so that each district in the Province and the City of Halifax will have a population unit compatible with efficient general public health nursing. A practical unit for public health nursing ranges from 3,000 to 5,000 per nurse depending on the district.

Medical

The situation in sanatoria concerning adequate medical staff should be thoroughly explored. The education and active preventive programme with medical students is rapidly decreasing the usual source of medical personnel, namely, the medical student or young graduate who developed tuberculosis and because of handicap and security was forced into sanatorium work, accepting terms of salary and living conditions because there was no choice. For practical purposes, this source is eliminated. Perhaps it is as well, for in addition to revealing a generally poor financial return for services rendered or available, there are distinctly new demands being placed on these medical staffs through the diagnostic problems created by mass radiography and the matter of clinical judgment in treatment. Sanatorium medical staffs now require a much wider knowledge of general medicine and this demand will increase in the future. Salaries up to the present are not sufficient to compete with other fields in medicine following the post-graduate training required.

It is therefore recommended that the matter of assuring an adequate financial remuneration, following post-graduate training, be explored.

Welfare

The committee does not feel competent to make any recommendations concerning welfare, at least without a special inquiry into principles and practices presently operative. The committee does desire to place on record its appreciation of the very real assistance which the Provincial Department of Welfare has provided in homes where tuberculosis has affected the bread-

winner and the more recent advance of assisting financially children defined under the act as orphans—that is children whose parents are both disabled, or those who have one parent dead and the other disabled or both parents dead.

Your sub-committee, while registering approval of all that has been and is being done in the line of welfare, does recommend that such allowances that are granted should continuously have in mind the rising cost of living.

Voluntary Agencies

The official voluntary agencies having to do directly with tuberculosis are now represented by a central organization, the Nova Scotia Tuberculosis Association, the executive and council of which is representative of all sections of the province, each local association selecting members for the Council.

These organizations were leading the fight against tuberculosis prior to any governmental assistance and have done much to form the public opinion and education which has led to the present situation.

The continued value of their activities across Canada is evidenced by the proceeds from the Christmas Tuberculosis Seal sale which last year was over \$1,000,000, all of which has assisted in the control of tuberculosis through unofficial and voluntary agencies. The financial return is one gauge, but the educational value and the endeavour in each locality emanating from the local Seal Sale Committees make an inestimable contribution toward tuberculosis control.

Your committee recommends that every encouragement be given these voluntary organizations, not only to continue, but to expand their influence in the control of tuberculosis.

Your sub-committee desires to re-affirm its opinion that this report can only be regarded as of interim nature, placing before you principles and reasons for those principles, which will be effective in the immediate and more distant future. If these principles are acceptable as a basis for a plan, this sub-committee will be pleased to study and recommend details which will implement the principles.

It is quite apparent that many of the recommendations are on the Federal Grant, but it is equally obvious that all the principles cannot be implemented in any one year, but the development of all is desirable.

Respectfully submitted

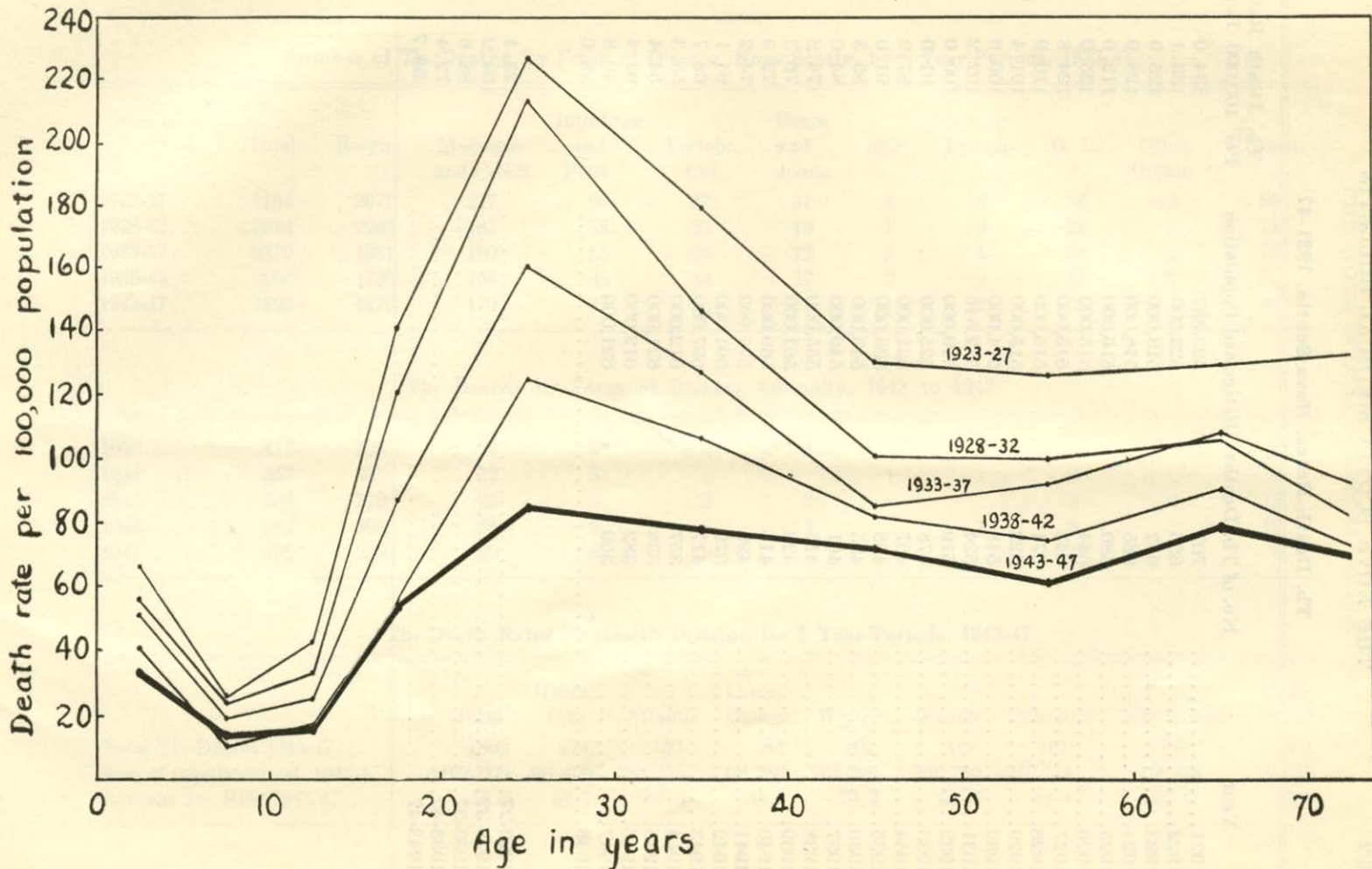
Charles J. W. Beckwith

Sub-committee on Tuberculosis

Age Specific Tb. Death Rates for Nova Scotia, by 5 Year Periods, 1923-47

	Total	0-4	5-9	10-14	15-19	20-29	30-39	40-49	50-59	60-69	70-
1923-27.....	123.4	66.5	26.4	41.7	140.6	228.4	179.9	130.0	125.8	128.9	131.3
1928-32.....	104.2	56.1	24.7	33.6	120.4	214.0	146.4	101.5	100.3	105.9	82.2
1933-37.....	88.6	51.8	19.5	25.1	87.6	160.7	127.1	85.5	91.7	107.2	92.3
1938-42.....	72.4	40.2	11.1	17.7	56.0	125.0	106.7	82.1	74.8	90.8	71.9
1943-47.....	58.7	34.0	14.3	16.8	55.9	84.1	77.0	71.5	61.0	78.4	68.2

AGE SPECIFIC TUBERCULOSIS DEATH RATES FOR NOVA SCOTIA, BY 5-YEAR PERIODS, 1923-47



Tb. Death Rates, Nova Scotia, 1921-47

Year	No. of Tb. Deaths	Estimated Population	Tb. Death Rate Per 100,000 Pop.
1921.....	702	523,837	134.0
1922.....	695	522,000	133.1
1923.....	652	518,000	125.9
1924.....	665	516,000	128.9
1925.....	580	515,000	112.6
1926.....	644	515,000	125.0
1927.....	643	515,000	124.8
1928.....	571	515,000	110.9
1929.....	522	515,000	101.4
1930.....	548	514,000	106.6
1931.....	524	512,846	102.2
1932.....	519	519,000	100.0
1933.....	478	525,000	91.0
1934.....	467	531,000	87.9
1935.....	488	536,000	91.0
1936.....	485	543,000	89.3
1937.....	461	549,000	84.0
1938.....	415	555,000	74.8
1939.....	428	561,000	76.3
1940.....	415	569,000	72.9
1941.....	429	577,962	74.2
1942.....	379	591,000	64.1
1943.....	417	607,000	68.7
1944.....	357	612,000	58.3
1945.....	338	621,000	54.4
1946.....	382	612,000	62.4
1947.....	309	621,000	49.8
1948.....			38.0
1923-27.....			123.4
1928-32.....			104.2
1933-37.....			88.6
1938-42.....			72.4
1943-47.....			58.7

Number of Tb. Deaths, by Form of Disease, Nova Scotia, by 5 Year Periods, 1923-47

	Total	Respir.	Meninges and C.N.S.	Intestines and Perit.	Vertebr. Col.	Bones and Joints	Skin	Lymph	G. U.	Other Organs	Dissem.
1923-27.....	3184	2671	227	96	37	31	4	5	36	12	65
1928-32.....	2684	2263	187	78	23	19	1	9	28	5	71
1933-37.....	2379	1981	190	65	25	12	3	4	23	1	75
1938-42.....	2066	1739	154	35	34	17	2	4	22	2	57
1943-47.....	1803	1479	179	37	15	11	1	3	28	1	49

Tb. Deaths by Form of Disease Annually, 1943 to 1947

1943.....	417	328	54	9	4	4	..	1	8	..	9
1944.....	357	305	32	5	1	..	1	1	3	..	9
1945.....	338	279	25	9	2	2	-	..	5	1	15
1946.....	382	308	38	9	5	3	..	1	8	..	10
1947.....	309	259	30	5	3	2	4	..	6

Tb. Death Rates by Health Division for 5 Year Periods, 1943-47

	Total	Halifax City	Atlantic	Lunen. Queens	Western	Fundy	Cobequid	Northumb.	C. B. Island
Total Tb. Deaths 1943-47.....	1803	224	150	84	202	188	161	237	557
Sum of population est. 1943-47....	3,073,000	381,409	288,255	234,280	287,396	366,740	370,744	344,458	799,718
Average Tb. Rate 1943-47.....	58.7	58.7	52.0	35.8	70.3	51.3	43.4	68.8	69.6

Health Division

Halifax City includes Halifax City.

Atlantic includes Halifax County, excluding Halifax City.

Lunenburg-Queens includes Lunenburg, Queens.

Western includes Shelburne, Yarmouth, Digby.

Fundy includes Annapolis, Kings, Hants.

Cobequid includes Cumberland, Colchester.

Northumberland includes Pietou, Antigonish, Guysborough.

Cape Breton Is'and includes Cape Breton, Inverness, Richmond, Victoria.

Doctor R. O. Jones then read the sub-committee's report on Mental Health Crants.

Dr. N. H. Gosse
Chairman Advisory Committee
Nova Scotia Medical Society
Halifax, N. S.

Dear Doctor Gosse:

Re; Mental Health Grants

Herewith a report of the sub-committee set up by your General Advisory Committee to consider the Mental Health Grants in Nova Scotia. This Committee consisted of Doctor James Muir, Truro, Doctor John R. Macneil, Glace Bay and myself as chairman. This Committee has not actually met during the year, but we have been in contact with each other by letter and in a general way have known what was going on as far as the spending of funds for Mental Health in Nova Scotia was concerned. We have also consulted other people outside the Committee whom we felt might possibly have some specific ideas which seemed important in the general health picture here. We have received every co-operation from Doctor Clyde Marshall, able to work in close co-operation with his Department.

The significant developments in the Province in the field of Mental Hygiene during this past year have been the following; first the strengthening of the teaching facilities of the Department of Psychiatry at Dalhousie University and the setting up in conjunction with the Victoria General Hospital and the Departments of Health of Nova Scotia, New Brunswick and Prince Edward Island, of post-graduate teaching in Psychiatry. This does not apply only to doctors but also social workers, psychologists, nurses and other individuals interested in mental health. With more money available for strengthening Mental Hygiene facilities in the Province the situation has proved to be the same here as elsewhere, namely that it was almost impossible to get trained personnel. It therefore became imperative that a scheme could be worked out whereby we could train our own personnel. At a joint conference with the representatives of Dalhousie University and of the Departments of Health of Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland a plan was drawn up, and later approved by the Federal Health authorities to set up a training scheme for the provision of personnel in this area. The Department of Psychology of Dalhousie University and the Maritime School of Social Work has co-operated in these schemes and are taking an active part in the training of psychologists and social workers. This plan has been proceeded with and at the present minute there are two residents in Psychiatry at the Victoria General Hospital who will enter the

mental health services of this Province and one who will go to Prince Edward Island. We also are engaged in training a social worker to work in the hospital in Newfoundland. We have taken part in the provision of clinical facilities for the training of clinical psychologists who are badly needed for our health services here. This training grant has also allowed the University and Victoria General Hospital to set up a clinic in the Halifax area with adequate psychiatric staff, psychologists and social workers which provides a consulting service for the Province through the general hospital and particularly a clinical service for Halifax and the vicinity.

As well as these local training efforts this grant has been used to provide training in other areas for people who already have had some experience in the local field. One physician has already received a year's training in Toronto and the second will go to Toronto this fall. A nurse has received post-graduate training in psychiatry and a social worker is receiving an extra year in psychiatric social work during the coming year and another physician has received special training in child psychology and will be working in the Cape Breton area. Thus the grant this year has been utilized very effectively, I think, to fill our desperate need for trained personnel.

Secondly: The beginnings of travelling clinics to meet the need for psychiatric help through the Province generally. A clinic has been set up in the Yarmouth area under the direction of Doctor R. R. Prosser and in the Cape Breton Doctor Bentley, who has just recently returned from the above mentioned course in Baltimore is just beginning to assume his duties there. While both these clinics need social workers and psychologists added to their staff this is the beginning of the provision of some field service throughout Nova Scotia.

Thirdly: The strengthening of the Nova Scotia Hospital. It has been possible to add new members to the Staff. A social worker will be attached to that Institution this fall. There have been psychologists working there during the summer and it is hoped that both these departments, as well as Occupational Therapy, will be built up in the very near future. There has been added facilities in the way of better buildings, more recreational facilities and improved treatment facilities. A project is being worked out whereby the University staff becomes consultants to the Nova Scotia Hospital and the Nova Scotia Hospital staff in their turn will take a more active part in University teaching and in the work of the general hospital. In this way it is hoped that there will be mutual profit. Plans are being developed for the erection of a new admission unit at the Nova Scotia Hospital which will provide active and up to date treatment for the acute psychoses that are admitted there.

Fourthly: The provision of better mental health facilities in our schools. One psychologist has been provided to the schools through the Mental Health Grants and it is hoped that more will be available in the near future. As well it is hoped special teachers will be able to get intensive training in mental hygiene, which can be incorporated directly into the school system.

Fifthly: The expansion of a general educational programme for mental health in the Province. Working in co-operation with the Department of Adult Education, the Mental Hygiene Division of the Department of Health and the Department of Psychiatry of the University have carried on an active

programme in general mental hygiene teaching, for the citizens of the Province in general.

We feel that these steps are necessary and desirable in the early stages of the development of an early health programme in this Province. When the serious shortage of personnel has been rectified, it will then be necessary to go on and think of further expansion in the different areas which as yet have not been explored. One which immediately comes to mind is what sort of thing should be done to meet the problem of the psychoneurosis? Should some type of sanatorium for this type of disorder be established, similar to the Army Rehabilitation Centre at Sunnybrook, in Ontario?

In conclusion we should like to express our appreciation to Doctor Clyde Marshall for the co-operation he has given our Committee during the year and to congratulate him on the improvement which has been made in the mental health services in this Province during the past year. We wish to extend an invitation to any members of the Society to contact us regarding their ideas for the improvement of mental health services in this Province, as they may see need from their special vantage points.

Yours very truly

(Sgd.) R. O. Jones, M.D.

Chairman Mental Health Sub-committee
Advisory Committee to the Nova Scotia
Government on the Federal Health Grants

The following report was then read by Doctor N. H. Gosse.

Report of Sub-Committee on Federal Grant for Venereal Disease Control

Venereal Disease Control as at present practised in the Province of Nova Scotia can best be described by following a case of, for example, primary syphilis, through the period of diagnosis, investigation of contacts and treatment.

The supposed case, in the course of examination by the physician in charge, has a dark field and/or seriological examination done without charge at the Public Health Laboratory, Halifax, N. S. Reports are then sent to the physician, to the Divisional Medical Health Officer and to the Department of Public Health.

Once the diagnosis has been definitely established the physician is required to complete Form N. H. 1 and forward it to the Department of Public Health. This form gives pertinent information regarding the patient, stage of the disease, previous treatment, source of infection and contacts. The physician may accept responsibility for investigation of contacts and request drugs for treatment or he may refer the case to the Venereal Disease Clinic.

Though here, as elsewhere throughout this report, statistical information is lacking, it is probable that the great majority of cases are treated at established clinics. Free treatment is available for both syphilis and gonorrhoea, but it is probable that many of the latter are treated privately and not reported.

Clinics are in operation in the following locations:

Amherst	New Glasgow
Glace Bay	Shelburne
Halifax	Sydney
Kentville	Truro
	Yarmouth

On receipt of Form N. H. 1 the Provincial Department of Health notifies the Divisional Health Officer. A Public Health Nurse on the latter's staff visits the physician or clinic director to make certain that treatment is instituted promptly and carried out regularly. She gives assistance in locating contacts and persuades unwilling patients to report regularly for treatment.

It has been the policy of the Department to administer, through its clinics, alternating blocks of arsenic and bismuth, i.e. ten weeks of arsenic, then ten weeks of bismuth, one treatment per week for one and a half years.

In recent months Penicillin has been used in the clinics on selected cases and may become the routine treatment. Standards for treatment have not as yet been officially stated but approximately 5,000,000 units are given over a period of two weeks with satisfactory results. The drug used is Penicillin G. in Oil with Aluminum Monostearate 2%.

Gonorrhoea is handled in a similar manner with the exception that the Department of Public Health will supply free Penicillin only to the clinics. Inasmuch as the treatment of this disease is inexpensive, this policy is sound and encourages the less affluent to apply for treatment at the clinic where contact investigation can be carried out more efficiently.

Comments and Suggestions

1. Reporting—New cases for the year ending November 30, 1948, are as follows:

VDG	680
VDS	576

We believe that this represents only a small fraction of the actual number, many cases not being located. Some physicians object to the mass of information asked for on the report form (N. H. 1) and so do not fill it at all. A simple form, even a blank post card could convey the idea that the physician had a case to report. The Public Health Nurse could then obtain the necessary information. It has been suggested that a reasonable fee be paid for each case reported. Should any of these measures result in 100% reporting and contact investigation, the venereal disease problem would cease to exist.

2. Follow up—At present a nurse on the staff of the Divisional Health Officer takes care of this matter. It is only one of her many duties and suffers as a result. Many patients do not appreciate having to take treatment, free or otherwise. Treatment is often carried out intermittently because she simply does not have the time to devote to proper follow-up. With the shorter Penicillin schedules now being instituted regularity is essential and a Venereal Disease Nurse would be of great value. This is especially important if we are to find and treat the Penicillin—delayed cases of syphilis.

3. Laboratory—Earlier diagnosis and treatment would be possible if reports were available within hours rather than in days. Routine tests on patients hospitalized for brief periods have been reported after discharge and may not be seen by the physician in charge. This has resulted in delayed treatment in known cases.

Consideration should be given to the establishing of branch laboratories in the eastern and western ends of the Province.

4. Treatment—Free Penicillin is only available for cases of gonorrhoea treated at the clinics. It might be wise to make exceptions to this rule for indigent cases in areas remote from a clinic, contacts may be located.

We would recommend that free Penicillin be supplied for the treatment of neurosyphilis. It is our understanding that this matter is being favourably considered at present.

With various schedules of treatment being recommended for the different types and stages of venereal diseases it is suggested that a conference of clinic directors be called periodically.

5. To our knowledge, no attempt has been made in this Province to encourage mass blood tests. Publicity could be given to the advisability of testing those handling and serving food. More of our industries could be encouraged to demand blood tests as a pre-employment requirement.

6. Statistics, other than the number of new cases reported and the number of serological tests done are not available for this survey.

Respectfully submitted,

(Sgd.) D. F. Macdonald, chairman
C. L. Gosse
H. E. Kelley

Recommendations

1. A simple form for reporting.
2. A fee for reporting.
3. A Venereal Disease Nurse.
4. Speeding up of laboratory services.
5. Branch laboratories in the eastern and western ends of the Province.
6. Free Penicillin for indigent cases remote from a clinic.
7. Free Penicillin for treatment of neurosyphilis.
8. Conference of clinic directors—periodically.
9. Publicity to advisability of testing those handling food. Encouragement of industries to demand blood tests as a condition of employment.

Doctor N. H. Gosse moved that the Report of the Advisory Committee re Federal Health Grants, with its appendices as reviewed, be accepted. This was seconded by Doctor H. D. O'Brien.

Doctor T. C. Routley: "I have listened with a great deal of interest to these reports and I was impressed, as you all were, with their thoroughness,

and I was pleased to observe a large number of recommendations. It seems to me that we should be the correlating agencies in Canada whereby all the medical practice that is being offered in Canada will be in some way screened, so that we will have an united medical front. When you think of \$30,000,000 being granted for five years, and then may be for another five years, I think we can't be too vigilant in establishing sound principles of medical practice in this country.

Doctor Gosse's motion was carried.

Doctor N. H. Gosse advised that arising out of these reports was the matter of the appointment of an advisory committee.

Doctor H. W. Schwartz: "As they are just half way along in their work would it not be folly to change that committee now?"

Doctor J. J. Carroll moved that the Society appoint an advisory committee to the Government, five, as before. This was seconded by Doctor R. O. Jones.

Doctor R. A. Moreash moved that the committee that is now acting be reappointed. This was seconded by Doctor J. C. Acker.

Doctor J. W. Reid: "That committee has no power whatever, and is not recognized by the Provincial Government in any way. My feeling is that it should be no longer called an advisory committee; it should be called a watching committee."

The Advisory Committee, Doctors D. F. Macdonald, A. E. Blackett, H. G. Grant, J. P. McGrath, H. D. O'Brien, J. W. Reid, H. A. Fraser, M. J. Macaulay and N. H. Gosse, Chairman, were re-appointed, as moved by Doctor R. A. Moreash. Carried.

Doctor J. W. Reid: "I think we should make some expression of our thinking with regard to the individual who holds the portfolio of the Minister of Health. I would move the following—Resolved that insofar as The Medical Society of Nova Scotia feels that the health of the people of this Province will be best served by the efforts, at the highest policy level, of a man trained in medicine, we wish to place ourselves on record as hoping that the present government will do all in its power to place a medical man in the important post of Health and Welfare. I move the adoption of this resolution and that a copy be sent to the Premier of Nova Scotia."

Doctor Eric W. Macdonald: "I realize the desirability that the Minister of Health should be a medical man, but I am a little leary of a resolution passed by this body to the Government asking that this be so. In the event that our suggestion is not taken there might be repercussions. I would be more in favour of the Government or the Premier being reached in some more direct and private way."

Doctor J. A. Noble, "I would like to support Doctor Macdonald's thoughts in that regard."

Doctor H. G. Grant: "There is a feeling that a lay man could serve just as well as a medical man. When it comes to the final point the personnel of the department is what counts."

Doctor J. W. Reid's resolution was seconded by Doctor W. A. Hewat.

Doctor N. H. Gosse moved an amendment that instead of the resolution being sent to the Premier that the contents of the resolution be given to the Premier verbally and unofficially through the President. This was seconded and carried.

Dr. D. S. Robb moved a second amendment should a change in the ministry be contemplated. This was seconded and carried.

Dr. W. A. Hewat moved that this Society recommends that a system of intra and extra mural study on a part time basis be set up for the purpose of encouraging men already established in practice to obtain certification in the specialty of their choice, and that a standing committee of this Society be set up to accelerate and oversee this matter.

This was seconded by Doctor J. W. Reid and carried.

Doctor H. A. Fraser suggested that the incoming President be instructed to name this committee. He stated that the members had come to the end of a long hard session, and he wanted to thank them all for their co-operation all through the year, particularly to Doctor H. G. Grant, and offered his ongratuatlions and condolences to the new President, Doctor E. F. Ross.

Meeting adjourned at 6.50.

Correspondence

Halifax, N. S. November 22nd, 1949

Dean H. G. Grant
Dalhousie University
Halifax, N. S.

Dear Dean Grant:

Doctor for Spryfield

This is an extensive section, four miles from Halifax, requiring a physician.

The area extends from Sambro, Ketch Harbour, Herring Cove, St. Margaret's Bay Road to Armdale.

Population to be served would be approximately 8,000. In the district there are many churches, good schools, (Spryfield School itself must have 400 pupils), paved roads or roads now under construction for paving.

An office could be provided by Mr. Gardner, in the Drug Store building at Pine Grove Corner, which is the centre of this locality.

A doctor needs to come here and live in the village — servicing from Halifax is neither satisfactory to the doctor not the patient.

Would a graduate of 1950 consider this?

Thanking you,

Yours very truly

(Sgd.) S. R. Balcom.

Society Meetings

COLCHESTER AND EAST HANTS MEDICAL SOCIETY

The fall meeting of the Colchester-East Hants Medical Society was held on Friday night, November 25th, at Pryor's Guest House, Pictou Road, Bible Hill.

The President, Doctor P. R. Little and Doctors E. M. Curtis, S. G. MacKenzie, Sr., T. C. C. Sodero, J. A. Muir, W. J. MacDonald, H. R. McKean, R. F. Ross, H. R. Peel, C. A. Smith (who has recently opened a practice in E.E.N.T. in Truro), D. S. McCurdy of Truro, D. F. MacInnis of Shubenacadie, D. Ross MacInnis of Kennetcook, A. M. Creighton and D. Murray of Tatamagouche attended.

Following a dinner at 6.30 a professional meeting was held at which the following business was dealt with.

1. Maritime Medical Care Incorporated will pay for chest X-rays where there is not a free service by the Government in the community.
2. Public relations letters read and Doctor D. S. McCurdy appointed as Public Relations Officer.
3. Agreed to co-operate with The Medical Society of Nova Scotia in individually contributing for expenses of the Canadian Medical Association in Halifax, 1950.
4. Doctor Dan Murray of Tatamagouche was recommended for honorary membership in the Canadian Medical Association.
5. Two new members were elected to the Colchester-East Hants Medical Society, Doctor D. Ross MacInnis of Kennetcook and Doctor C. A. Smith of Truro.

We were fortunate in having with us as special guest speakers, Doctor Robert M. MacDonald, gastro-enterologist and Doctor H. C. Read, haematologist, of Halifax.

Doctor Read discussed Anaemia outlining the blood mechanism formation, use and destruction by being worn out or destroyed by disease. He gave a clear and simple classification, diagnosis and treatments.

Classification:

1. Impaired blood production from deficiency of (a) Liver factor, (b) Iron, (c) Thyroxin.
2. Toxic.
3. Bone space occupying tumors.
4. Increased blood destruction.
5. External loss of blood.

Dr. Robert M. MacDonald spoke in a very practical way of Duodenal ulcers. Their questionable aetiology, their diagnosis from:

1. History which is very important.
2. Physical examination which rules out other diseases and shows some epigastric tenderness.
3. X-ray which is not always conclusive.

The basic principles of treatment are fairly well agreed on.

1. Diet—bland, low residue, small frequent meals, antiacids.

2. Anti-spasmodics. Probably Belladonna and atropine are as useful as the more expensive ones.
3. Sedatives.
4. Avoid excess in all things—food, activities, smoking, etc.

These papers along with a general discussion made a very fine meeting. The visiting guests were thanked by Doctor R. F. Ross and after repairing two "ulcerated" auto tires which had ruptured during the meeting we hope they had a pleasant journey home.

D. S. McCurdy, Secretary-Treasurer

Personal Interest Notes

AT the recent convocation of the Royal College of Physicians and Surgeons of Canada held at Toronto the following Dalhousie graduates were admitted to Fellowship.

F.C.R.S. (C.)

Doctor John H. Charman, a native of Wallace, son of Mr. and Mrs. M. M. Charman of Halifax, who graduated September 1, 1943.

Doctor David L. MacIntosh, a native of Bedford, now in Toronto, son of the late Rev. and Mrs. M. H. MacIntosh, who graduated in 1939.

Doctor Fred H. Wigmore, a native of Emerald, P. E. I., now in Moose Jaw, Saskatchewan, who graduated in 1935.

Dr. James W. Long, a native of East Dalhousie, Annapolis County, now in Toronto, who graduated in 1942.

Dr. Donald A. Thompson a native of Stellarton, N. S., now in Bathurst, N. B., who graduated in 1933.

Dr. F. Gordon Mack, of Halifax, son of Dr. and Mrs. Frank G. Mack of Halifax, who graduated in 1944.

F.R.C.P. (C)

Doctor J. Albert Fownes, a native of Baddeck, who graduated in 1942.

Doctor Hugh E. Christie of Amherst, who graduated in 1939.

Doctor J. F. Bates of Sydney, who graduated from Dalhousie in 1926, has been appointed to the pensions commissions of the Department of Veterans' Affairs at Ottawa.

Doctor Denis R. S. Howell with his wife and twin sons recently moved to Halifax from Toronto. They had formerly spent several years in England where Doctor Howell was with the Royal Navy during the war.

Doctor and Mrs. Allen R. Morton of Halifax spent two weeks in New York the end of October.

Doctor C. C. Stoddard, Dal. 1938, of Halifax, head of the department of anaesthesia at the Victoria General Hospital, has recently been honored with a Fellowship in the International College of Anaesthetists.

We are glad to report that Doctor L. M. Morton of Yarmouth, who underwent an operation early in November is well on the road to recovery.

Doctor R. P. Smith of Halifax, who recently resigned from the position of provincial pathologist, is now in Wisconsin.

Doctor J. A. Webster of Yarmouth attended the Congress of the American College of Surgeons at Chicago in October and received his Fellowship in General Surgery. Mrs. Webster and son, Charles visited her brother Doctor John M. McGowan in Quincy while Doctor Webster was in Chicago, and on his return from Chicago he attended the meetings in Boston of the National Gastroenterological Association. They travelled by air and enjoyed the trip very much.

Obituaries

THE death occurred in Halifax on December 3rd. of Doctor Robert Hugh MacLeod after a long illness. He was born in Burnside in 1884 fourth son of the late Captain and Mrs. Angus MacLeod. After graduating from Pictou Academy he taught school at Westville for several years, later becoming principal of schools in Lunenburg before returning to Pictou Academy as science teacher. Later he entered Dalhousie Medical School and graduated in 1925. His first practice was at Musquodoboit where he remained until 1929, when he joined the United States Public Health Service, under auspices of the Rockefeller Foundation. A course in Public Health in Mississippi was followed by several years of service in this line in Kentucky and West Virginia. His last post in the United States was Director of the West Virginia State Health Department at Charleston. He resigned this post to resume private practice but owing to illness was forced to suspend all medical work for a time. He went to England in 1936 for post-graduate studies and entered private practice in the greater London areas until 1939 when he returned to practise in Upper Stewiacke and later in Halifax. Surviving are his wife, the former Ola Redden of Caribou Mines, and a son, James William, aged eleven.

The death occurred in Punta Gorda, Florida, on November 8th, of Doctor Lorne Wilborn Harris. Doctor Harris was born at Bear River in 1878, son of William and Loretta (Henshaw) Harris, and after attending Normal School at Truro taught school at Bear River and then entered Jefferson Medical School in Philadelphia graduating in 1908. Besides his wife, the former Aileen Bowes of Shelburne, he is survived by a daughter, Mrs. Eva H. Thompson of Newton, Centre, Mass., and one sister, Mrs. Walter Payson.

Doctor William Alexander Chisholm, a native of Antigonish and retired New York specialist in disease of the ear nose and throat, passed away suddenly in Mount Dora, Florida, on November 10th, where he and Mrs. Chisholm were spending the winter. A son of the late Duncan Chisholm and Mary (Cameron) Chisholm, he was born at Salt Springs, Antigonish County, in 1866. He studied at Pictou Academy, graduated in Arts from St. Francis Xavier University, and taught school in different parts of Antigonish and Guysborough Counties before studying medicine. After attending the Dalhousie Medical

School, 1892-95 he entered Bellevue Hospital Medical College, New York, and graduated with honours in 1896, and practised his profession in that city for over thirty years until his retirement. Doctor Chisholm married Adelaide Berry of New York in 1923, and after he stopped practising he and Mrs. Chisholm spent their summers at Cape George and the winters in Florida.

The BULLETIN extends sympathy to Doctor and Mrs. D. G. Timmins of Ship Harbour on the death of their infant son, Maxwell John Daniel, on November 11th; to Doctor J. W. Reid of Halifax on the death of his step-mother, Mrs. Lizzie Adams Reid, wife of the late Doctor J. W. Reid, M.L.A., at Windsor on December 3rd; to Doctor J. J. Carroll of Antigonish on the death of his mother, Mrs. Emma Cora Carroll, wife of the late William A. Carroll, at Halifax, on November 29th, and to Doctor H. A. Fraser of Bridgewater on the death of his mother, Mrs. A. L. Fraser, wife of Rev. Dr. A. L. Fraser, at Halifax, on December 5th.

The death occurred at Hinckley, England, in November, of Harry Munn Godfrey, M.D., F.R.S.C. Doctor Godfrey was born in 1891, and graduated from the Dalhousie Medical School in 1915. He was badly wounded in the first world war in which he served with the Royal Army Medical Corps, and went to Hinckley from Manchester in 1932, and was in practice with Doctor Charles Murray, and was later appointed surgeon to Hinckley and District Hospital. He was a brother of John Wilfred Godfrey, lawyer, who died last spring in Halifax.

NOVA SCOTIA MEDICAL BULLETIN

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