The Dalhousie University Medical Museum

Its Place in the Medical Community

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HISTORICALLY the term Museum was the name given the early Alexandrian university building which served as a research and educational institute in all the then known fields of endeavour. With the widespread re-organization of Museums consequent upon the war the almost universal trend is away from the idea of a Museum serving as a mere storehouse and is back to the original Alexandrian concept.

The role which a Medical Museum can play in the collection of material and the provision of educational and research facilities within the Clinical Departments of a University and Hospital has greater possibilities than have yet been realized. Recent visits to medical centres on both sides of the Atlantic revealed that the value of medical museums for teaching and research in a medical community was being strongly stressed.

Modern Concept of a Medical Museum

While many are familiar with departmental museums within the structure of the modern medical school, fewer appear to be familiar with the precise meaning, objectives, or possibilities of a Medical Museum.

Departmental collections within the pathological sphere have been, and often are, little more than a series of pickled specimens in bottles reflecting no especial judgment in either their selection or presentation. It is not surprising, therefore, that many such collections have been regarded as of little educational value, and are seldom visited except before an imminent examination.

The tendency in Britain, America and Canada as shown by recent visits to nearly fifty centres in these countries is toward the Medical Museum as a planned teaching and research institution. This is in keeping with the modern trend toward unity in medical education, since the defects of the rigid departmental or compartmental method of instruction have become obvious.

Recognition of the medical museum as an important teaching instrument and co-ordinating link between departments, has recently caused a number of eastern Canadian medical schools and hospitals either to establish such museums or reorganize their collections in this direction. This change of attitude has also been prompted by the realization that a suitable panel of patients is not always available for instructional purposes, and that much may be learned from specially prepared case records and specimens.

At Dalhousie University there has been established a Department of Medical Museums whose objectives may be defined as follows:

(i) The creation of a teaching collection, suited to both undergraduate and graduate needs, and utilizing not only pathological specimens but also clinical records and material.

(ii) The presentation of the commoner human diseases in all their aspects in order to emphasize the need for correlation of medical science and clinical practice, in the fields of pathological-anatomy, medicine, surgery and obstetrics.

(iii) The establishment of loan collections, in the form of "handling" specimens, lantern slides and reproductions, for student and staff instruction in all the clinical departments.

(iv) The commencement of a depository or research collection, and the provision of facilities for those interested in clinical research.

The Army Medical Museum in Washington, the Wellcome Museum in London, and the Medical Museums of the Mayo Clinic, as well as many modern hospitals have shown how these principles may be put into practice.

These selfsame principles may be applied if anything more readily to the smaller university medical school since there the lesser volume of material favours more studied selection and presentation. A medical museum provides a centre for the proper preservation and utilization of a hospital's clinical and pathological teaching resources. It is an economic means, moreover, of providing a number of clinical departments with research facilities necessary to the encouragement of original work among the clinical staff, without expensive duplication of basic equipment and laboratory space.

General Organization and Procedure

The nature of the museum, its immediate and ultimate aims, and working procedure were carefully drawn up and submitted to the university authorities, prior to the establishment of the department. With their approval and the clear understanding that the museum should take the form of a medical museum, work commenced.

The objectives have already been set forth, but with the limited staff at our disposal, and the necessity for complete revision of the existing pathological collection, it was deemed wiser to devote the first or gestational years to the formation of a nucleal teaching collection suited to immediate student requirements and capable of later expansion and improvement.

This first phase of development, which necessitated the simultaneous equipping and establishment of museum laboratories, apart from complete reconstruction of the old museum, has almost been completed.

Selection of Material

To fulfil its obligations as a teaching museum it would be unwise for the medical museum to collect and present everything that came its way as such would only lead to a haphazard and somewhat bizarre collection resembling the older and now obsolete type of German university museum of morbid anatomy. Again, the acceptance of donations with the obligation that they be exhibited is now generally held to be inadvisable. The decision to retain and/or exhibit must rest with the directorial staff and follow a systematic pattern. What is retained and displayed will naturally be influenced by the parent hospital, its practice and experience. To do otherwise is to overlook the educational duty to the local community and merit the appellation of exotic pathology, unless the objective is that of giving instruction in some

particular field such as tropical medicine. The commonplace should accordingly take precedence over the rarer and grotesque, for both the undergraduate and graduate student wish to examine the features of the diseases they are most likely to encounter. It is important to point out that this does not imply the destruction of rarities but rather their storage with related data until such time as a use for them may be disclosed.

This leads to the possible uses to which a specimen may be put. Following its removal in the operating or autopsy room it should of course be submitted to the scrutiny of the pathologists. At this time it is extremely important that the incisions be planned to best expose the pathological and anatomical features in a manner consonant with the histological requirements of the case, attendant clinician and pathologist. In short the pathologist must have such tissues as will allow him to do justice to the case while bearing in mind the possible research or teaching value of the material under his hand. For now is the time when consideration must be given to the advisability of securing gross-specimen photographs, postmortem radiographs, injection studies or any other supplements valuable to the permanent records and future interservice discussion since the specimen represents the meeting point of clinician, radiologist and pathologist.

A museum accession must thus first be considered as either a future research, exhibition or handling specimen. Good accession records must be kept together with the clinical data lest future presentation be robbed of valuable correlative interest.

The Medical Museum

The large room formerly used to house the pathology collection has been extensively renovated and altered to meet the needs of the new museum.

The hall has been arranged so that there is a central aisle leading off into six bays each of which is devoted to one of the body systems. Cascade or tiered benches line each bay and their shelves have been arranged at optimal levels from the floor for restful inspection of the specimens.

These benches have been designed to conform with the internal pillared architecture of the room and placed to ensure uniform illumination from artificial sources. To avoid cross illumination and the harmful effects of sunlight on specimens and illustrations the museum has been fitted with fluorescent lights and venetian blinds. Cross ventilation and adequate heating have also been considered, and tables and chairs provided for group instruction and ease of study. An electric clock has been installed to facilitate observance of class periods.

Within the bays the exhibits have been arranged in organ groups further divided into individual diseases. This has been done by the method of paragraphing, or fixing vertical strips of red plastic to the tiered benches, thereby dividing them into labelled areas corresponding to the main groups and subgroups of clinical and pathological classification. This facilitates study; for example the student on entering the bay devoted to the cardiovascular system can go immediately to the endocarditis, aneurysm or other area occupying his interest. In these areas are gross specimens, summaries, illustrations and models.

The material presented has been critically selected in the belief that there

can be too many specimens and that the student will gain more by the careful study of a few representative specimens.

Carefully chosen individual cases of the commoner diseases are therefore exhibited. Each specimen, after a dissection planned to reveal as many of the gross aspects of the diseased tissue as possible, is mounted in a museum jar with a sea-green background. Apart from being restful to the eye and providing a colour contrast, the sea-green background causes its red complementary (Ostwald Colour Circle) to be superimposed, subconsciously of course, upon the specimen with the apparent enhancement of its reds. No preservation method yet known can capture the colour or character of fresh tissue but that is no excuse for presenting the student with dirty, distorted, and undissected formalin-fixed pathological specimens which rapidly kill interest. Hence the necessity of approximating, as far as possible, the original colour and contour, with the added realization that a good visual impression often epitomizes a pathologic state. Fresh pathology demonstrations are periodically displayed in a low temperature case designed for the purpose.

In our museum we have intentionally retained the glass museum jar for most exhibition purposes. This permits of the display of a large portion, if not the whole organ, thereby providing an anatomic lead or means of orientation often denied one when a plastic cell or watchglass mount with a mere slice of tissue is presented. Two useful purposes are served thereby; firstly the observer revises his anatomy, and secondly interprets the physical signs and symptoms (given on the accompanying case record) in terms of the underlying morbid anatomy. Certain American schools now aware of the inadequacy of making cytologic morphology the paramount method of teaching pathology are showing a healthy tendency toward devoting more time to the gross structural and functional aspects of diseased tissue. Pathological anatomy, in its broad sense, is an important study for the student of general medicine, as is evidenced by the increasing number of students of all years who now avail themselves of the museum's facilities.

Visual education should not rest on pictorial methods alone, but utilize the printed word, object and picture. Relating to each specimen, and filed in history boxes placed in each divisional area, are descriptive cards mounted in a clear plastic (pyralin) holder (6¾ x 7¾ ins.) bound with fabricoid tape. These cards first point out the salient normal and pathological features of the specimen. Next follows a short essential history with extracts from the clinical and pathological case records. Finally there is a discussional or integrative paragraph which seeks to link not only the features of the specimen with those of the history, but also to emphasize the constant need for integration of laboratory method and clinical practice.

Illustrations also accompany the specimens, and take the form of either diagrams, reproductions or photographs. These have been selected with the object of clarifying and emphasizing certain features and portray clinical, radiographic, microscopic or other appearances of the disease state. Pictorial displays arranged on Multiplex viewing panels affixed to the wall within each bay are in course of preparation. These are devoted to subjects, such as syphilis and certain endocrine states, etc., which require clinical photographs for their fuller presentation. Many fine illustrations lie hidden in journals and atlases that would serve a better purpose by being placed on display. The reader will recall illustrated demonstrations prepared by his fellow clini-

cians which on the conclusion of medical conferences and refresher courses have been dismantled and served no further useful purpose. Such demonstrations of current medical interest and practice could advantageously be placed at the disposal of the university teaching museum.

Teaching in the Museum

A teaching programme often requires the demonstration of disease states which may not be available in the hospital wards when required. Although there is no substitute for bedside examination of a patient, modern visual techniques with their high standard of reproduction when combined with properly prepared specimens and models can go far to closing such gaps in a students' education. The material in a medical museum therefore can be made to play an important role in clinical instruction.

Specimens may be used in various ways for teaching purposes. Instruction within the museum may take the form of small group demonstrations in the company of an instructor, with emphasis on verbal explanation. While this method may possess advantages, it has certain disadvantages in that few of the group can see, let alone examine the specimen, while attempting to grasp the discussion. As a form of museum instruction it is therefore considered somewhat passé, and inferior to arranged displays (vide infra).

Emphasis is best placed on the development of individual interest and application. The student should learn to realize that specimens represent the things about which books are written, and that accordingly it is a matter of personal responsibility to acquire a familiarity with and understanding of disease processes. On expansion of the museum an introductory section devoted to the basic principles of general pathology will be added for the benefit of junior students.

The method of paragraphing practiced in the museum facilitates the ready selection of desired material. This, combined with the carefully written textual summaries, quickly accustoms the student to use the exhibits in a library-like manner with consequent acquirement of the habits of observation and self-reliance.

In time the accumulation of sufficient material will warrant the arrangement of special displays, which after being exhibited for say a week, will be discussed by a speaker or speakers selected from various departments. Such clinical displays arranged with the assistance of the interne and junior staff, and comprising the case records, illustrative material and specimens from a series of cases, would encourage the student to assume more than an auditory role at the discussion.

Meanwhile regular clinics are held in conjunction with the professor of medicine, which stress the necessity of integrating pathological or clinical anatomy with the practice of medicine.

Apart from the weekday study facilities in the museum, groups under the monitorship of senior students meet during the weekends with the purpose of preparing for Final and Dominion Council examinations. Regular visits to the museum now also constitute part of the training course for nurses, who find the correlated displays helpful to their studies.

The museum too has begun to play an important part in postgraduate instruction for it is much used by medical men preparing for either registration or higher examinations, especially during the Dalhousie Refresher Course.

Clinics and such systematic lectures as are necessary in the various clinical subjects are enlivened by the judicious use of Kodachrome lantern slides. It is hoped therefore that the hospital personnel will be generous enough to place some of their photographic material and slides at the disposal of the museum for filing in the lantern slide library that has been started for the use of the teaching staff. Regular slide projections could then be planned for the benefit of various departments and study groups. The loan collection described below will constitute an additional teaching aid, but operation of these services is at present precluded by the disposition of the laboratories.

Loan and Research Collections

All modern museums now distinguish between exhibition, study and research specimens. The greenbacked exhibition specimens displayed on the shelves, although regarded as permanent only until better examples are forthcoming, are not intended for handling purposes, since well dissected and properly displayed material renders handling unnecessary. Handling causes blood pigment to diffuse out into the mounting medium, and is uneconomical of material and time, especially when the museum personnel might be better employed in developing other projects.

Provision for handling or study specimens has, however, been made. This collection, now in process of formation, will consist of duplicate and unusual specimens for the use of instructors or special students, and will be housed in the cupboards built beneath the display benches. These cupboards have been arranged to coincide with the labelled areas on the display bench above, thereby making for systematic storage and immediate availability. It is hoped that this collection will soon reach such proportions that it will function as a loan collection or specimen library.

As regards research material, the department cannot yet boast a very pretentious depository, but specially instructive or rare material is carefully catalogued, labelled, and stored in a small forced draught fixation room especially fitted out for the purpose. A large depository is regarded as a very necessary feature in the expansion plan if both the museum and hospital are to be properly served. This project is discussed elsewhere.

In addition to these collections, attention has already been drawn to the lantern slide library that is also in process of formation. A representative microscope slide collection of the specimens on display would appear to be very desirable. Microscopes have been purchased, but the project must remain in abeyance until adequate technical assistance is forthcoming.

Visiting Hours

Since the museum contains valuable material and equipment it is not left unattended. Unfortunately the size of the museum staff does not permit any one member being on duty all day in the museum, but the casual visitor can usually gain admittance by crossing the street to the museum offices.

The medical students themselves, however, have provided monitors who open and close the museum and see to the maintenance of proper study conditions. The exact times of admission along with the name of the monitor on duty are posted on the noticeboard outside the museum.

With additional staff it is intended to run the museum like the medical library, but in the meantime the cooperation of the monitors and students who use the museum is greatly appreciated.

The Administrative Offices

The administrative offices and preparation laboratory in connection with the Medical Museum are not situated in the Pathological Institute, but across the street in the Cathedral Barracks. This arrangement while not very convenient, since it necessitates the transference of all specimens and equipment to and fro, was dictated by the lack of space when the department was started.

The rooms there have been arranged so that there is a general preparation laboratory, small fixation room or depository for the collection of museum and research specimens, dark room, store room and an office which also serves as a draughting room.

The Depository

The space for fixation and storage purposes is somewhat limited, but it is hoped that the authorities will be prudent enough, when a move is made to permanent quarters, to make provision for a large depository in order to halt the daily waste of teaching and research material which has exercised the minds and aroused the indignation of not a few members of the clinical staff.

The proper storage and cataloguing of operation and autopsy material is an important service which should be provided by the modern hospital. Since a depository, while a necessary adjunct to a medical museum, also provides the clinical and pathological personnel with an invaluable collection for follow-up, reference and research purposes. The relation which it would bear to the work of the Cancer Clinic requires no elucidation. It will be apparent that such a service requires constant attention, adequate space, and really reliable technical assistance to record the material and control evaporation. A depository is best placed in a basement and must be fitted with proper ventilating devices to counter the formalin hazard which becomes very real when large areas are given over to preserved specimens.

The Anatomy Museum

This museum which was founded by the author in 1939 has been on various floors of the Forrest Building. Started in the old medical library, it was recently moved to new quarters specially designed for the purpose on the top floor of that building.

Arranged on a regional basis, it displays dissections, illustrations, and models calculated to assist the medical student in the study of anatomy, and is open during the day while classes are in progress in the building.

Although the New York State Board commented favourably on the collection, a plan of reorganization on a more functional basis has been drawn up. Since anatomy is as much the handmaiden of medicine, as it is of surgery, the recast will depart from the orthodox anatomical presentation seen in most museums. Apart from displaying body structure, as well as developmental and geriatric change, the museum will take the form of a teaching collection of applied or clinical anatomy as functional in its application as it is possible for a collection of dead material to be. To this end a system of presentation has been planned which will form the subject of a later paper.

Relation of the Medical Museum to Clinical Research

Since medical museums derive their material from clinical sources their research is closely linked with that of the clinical departments. In addition, the use of specialized skills and techniques in the preparation of this material

has caused them to assume an important role in the conduction of certain types of clinical investigation. For example, the recent marked advance in the understanding and treatment of congenital cardiac conditions owes no small debt to the persistent activities of the International Association of Medical Museums, and our museum likewise is willing to assist the local body interested in this field.

To quote from the Mayo Clinic Division of Publications: "As time has proceeded the value of the museum for research has become more and more apparent. To-day it ranks next in importance to the clinic records of the patient as an educational source. The latter may be considered second in value for educational purposes, the resource of greatest educational importance being the patients themselves." The Mayo Clinic now has no less than four museums that are used for research and postgraduate instruction and from which technical exhibits carrying graphic information on medical matters are annually sent to medical conventions all over the country.

A medical museum can therefore serve the clinical departments as a research centre, providing certain facilities and services distinct from those afforded by the biochemical, pathological or other hospital services. In brief it can be used to centralize basic equipment common to the needs of these departments, as well as furnish workroom and technical assistance required by their personnel in the execution of special problems.

Since one swallow does not make a summer, it will be understood that the research activity within a university teaching hospital is directly proportional to the facilities provided and the number of staff members who can be encouraged to engage in clinical research. Modern hospital administration recognizes that the cost of preparing original scientific work is a legitimate expenditure, since the standard of both medical care and staff education is enhanced by its application.

The medical museum should therefore be placed in such a position as regards space, staff, and equipment, that it would be enabled to furnish depository, illustration, and special technical services (e.g. subgross dissection, microradiography, moulage construction, etc.) Such a department should stimulate both undergraduate and graduate education and research, while affording both the resident and teaching staff of the hospital the opportunity for individual participation in investigative problems.

In medicine good research requires continual contact with patients, since the experimental method exclusively pursued tends to prove somewhat narrowing. There is room here for greater development of clinical investigation or what has been designated applied research. Our medical records contain much that should be subjected to review and study, and the writer is convinced that both our junior and senior clinical personnel require little impetus other than the means of properly studying the material which now almost daily goes to waste. With the provision of improved facilities for clinical research, grants will surely follow, and our hospital research output add stature to our medical school.

In conclusion we gratefully acknowledge the assistance we have received from the professorial and technical staff of the local Pathological Institute. To the directors of the Wellcome Museum of Medical Science in London, and the Medical Museums of McGill and Toronto Universities we owe thanks for many helpful suggestions.

Minutes of the Semi-Annual Meeting of the Executive of The Medical Society of Nova Scotia, 1949

THE semi-annual meeting of the Executive of The Medical Society of Nova Scotia was held at the Dalhousie Public Health Clinic, Halifax, N. S., on Tuesday, December 13, 1949, at 2.30 p.m.

Present: Doctor E. F. Ross, President; Doctors J. J. Carroll, H. G. Grant, R. O. Jones, S. W. Williamson, G. R. Forbes, P. S. Cochrane, S. Marcus, W. A. Hewat, A. E. Blackett, G. A. Dunn, V. O. Mader, A. R. Morton, J. F. L. Woodbury, H. B. Havey, W. J. MacDonald, H. J. Martin, N. H. Gosse, J. S. Robertson, A. L. Murphy, H. D. O'Brien, P. E. Belliveau, H. A. Fraser, J. G. B. Lynch, E. I. Glenister, M. E. B. Gosse, C. B. Stewart, chairman of the committee appointed to make a study for a full time secretary for the Maritime Provinces, A. D. Kelly, Assistant Secretary of the Canadian Medical Association, and Mr. H. S. Farquhar, Director of Old Age Pensions and Mr. F. R. MacKinnon, Director of Child Welfare, who were present by invitation.

The meeting was called to order by President E. F. Ross.

Regarding the annual meeting in 1950 Doctor H. G. Grant quoted the rates from The Nova Scotian and Lord Nelson for rooms in which meetings could be held. After some discussion it was moved by Doctor A. E. Blackett that the business part of the annual meeting be held at some time agreeable to the Executive and not during the annual meeting of the Canadian Medical Association which is to be held in Halifax the week of June 19th. This was seconded by Doctor G. A. Dunn.

Doctor A. D. Kelly advised that the Canadian Medical Association had written to the other Maritime Provinces suggesting to them that they should select dates for their annual meeting right after Labor Day, and he thought the time for a one or two day meeting in Nova Scotia might be the last two days in August or the first of September.

It was moved by Doctor A. E. Blackett that the chairman arrange to hold the annual business meeting early in September in conjunction with the other Maritime Provinces and that it be held in Halifax. This was seconded by Doctor J. G. B. Lynch and carried.

President E. F. Ross: "As you know at the last meeting of the Society we agreed to certain features about the medical care of old age pensioners and recently an agreement, actually two days ago, was submitted by the Department of Welfare for the purpose of us considering it at this meeting. The fee of seventy-five cents was agreed to last Fall. During the past year the Executive of the Society agreed that the Maritime Medical Care Incorporated be the administrative agent for our Society for which they would receive 7% of the money so received from the Department. We have asked Mr. F. R. MacKinnon and Mr. H. S. Farquhar to attend our meeting this afternoon as there are certain points we do not understand."

The following agreement was then read by Doctor H. G. Grant.

THIS AGREEMENT made this........................day of....................................A.D., 1949
Between:

HIS MAJESTY THE KING in the Right of His Province of Nova Scotia, represented in this behalf by the Honorable Minister of Public Welfare for the said Province, hereunto authorized by Order in Council dated the..............................day of ....A.D. 1949, (hereinafter called the "Minister"),

OF THE FIRST PART

—and—

THE MEDICAL SOCIETY OF NOVA SCOTIA, a body corporate, (hereinafter called the "Society"),

OF THE SECOND PART

WITNESSETH that in consideration of the covenants, promises and agreements herein contained to be observed, performed and paid by them respectively the Parties hereto mutually agree as follows:

For the purpose of this agreement

1. (a) "Recipient" means a person to whom or on whose behalf a pension or allowance is paid under the Old Age Pensions Act or The Mother's Allowance Act, or a parent or a child on whose behalf an allowance is paid under the letter act.
   (b) "Medical Service" includes medical advice and attention in the house of a recipient or in the office of a member of the Society together with the drugs and dressings ordinarily used by a doctor in making a call or attending a patient in his office but does not include
   (i) surgery other than minor procedures designated by the Society and approved by the Minister:
   (ii) medical aids, appliances or supplies.

2. The Minister will provide the Society with a list showing the names of all recipients at the date of the list, their address and other relevant information, and not less frequently than monthly thereafter will give the Society the names, addresses and other relevant information of persons who are to be added to or deleted from that list, and notices of changes of address of persons on the list.

3. The Minister will pay to the Society the sum of seventy-five cents per month for each recipient.

4. The Minister will approve a form of Identification Card to be provided to each recipient and will use his best efforts to ensure that any Card issued to a recipient shall be returned to the Minister when the recipient dies or ceases to be a recipient.

5. The Society will provide for each recipient such necessary medical services as a member of the Society can reasonably provide in his office or in the home of the recipient, but not in a hospital, upon presentation by the recipient to a member of the Society of an Identification Card in the form approved by the Minister.

6. The Society will select from its members, subject to approval of the Minister, one or more committees for the purpose of examining and certifying the accounts for medical services provided under this agreement.

7. All accounts received by the Society under this agreement shall be referred to a committee so selected, which shall certify to the reasonableness thereof and the Society shall fix and pay to each of its members from the payments made under clause 3 the amount to which that doctor is entitled on the basis of the certificate.

8. The administration expenses of the Society chargeable against the payments to the Society under clause 3 shall be subject to approval of the Minister.

9. When in the opinion of the Minister medical services have not been provided in accordance with this agreement the payments provided in clause 3 may be withheld until the Society satisfied the Minister of compliance with this agreement.

10. The Society will account to the Minister from time to time upon his written request for the expenditure of the money paid to the Society under clause 3 and the books of account of the Society shall be opened to his inspection or to the inspection of any person designated by him for the purpose.

11. This Agreement shall take effect on the .... day of.................... A.D., 19..............and shall continue for one year thereafter. If neither party has given to the other notice in writing sixty days before the expiration of the said term of one year of his or its desire to terminate this Agreement it shall continue in force until the expiration of three months from written notice by one party to the other of his or its desire to terminate the agreement. Upon the expiration of three months from the giving of such written notice this Agreement shall come to an end and be of no further force or effect.

IN WITNESS WHEREOF this Agreement has been executed by the Minister of Public Welfare and by The Medical Society of Nova Scotia

SIGNED, SEALED AND DELIVERED in the presence of

....
Minister of Public Welfare

....
Medical Society of Nova Scotia

....
President
Secretary

Doctor G. A. Dunn asked whether the agreement included *all* drugs.

Doctor W. A. Hewat stated that with regard to fracture reduction it would be considered an office procedure in a good many small places.

Doctor E. F. Ross did not think that the newer drugs which are very expensive could be provided under such care.

Doctor S. W. Williamson said that there was nothing in the agreement about mileage.

Doctor W. J. MacDonald stated that the newer drugs lessened the length of time necessary for treatment.

Doctor H. G. Grant did not think the Society should contract for seventy-five cents if they were prohibited from using drugs.

Doctor E. I. Glenister asked that the clause regarding drugs be read again which was done by Doctor E. F. Ross.

Doctor J. G. B. Lynch: "I can't see any loop-hole, particularly to a country doctor. If a man is called ten or twelve miles in the country to see a patient and if he needs drugs and if he has them, he will use them. If the patient cannot pay for the service, he cannot pay for the drugs."

Doctor E. I. Glenister: "The doctor would be stuck for the drugs."

Doctor J. S. Robertson stated that on the advice of the Minister recommendation was made to the Department of Welfare that the use of drugs would be excluded, and that emergency medication would not be included. The point to be decided is what is emergency medication.

Doctor W. J. MacDonald stated that at the meeting at White Point the motion had been passed that the Society accept the amount of 75c; that on the various insurance policies it was just a matter of classification as to what drugs had been used. He would like it clarified as to what the insurance men

provided in medical care in ordinary cases, because the same should apply to this agreement..

Doctor N. H. Gosse: "There are certainly a few things that call for serious review; they are little things but should be very carefully gone over. There are some things that we should settle now, things that will have to be changed. If Maritime Medical Care Incorporated is to guarantee medical care, it should be written in right now. If Maritime Medical Care Incorporated is the approved agent of this body, we must have the approval of the Department of Welfare to cover it. I would suggest that we take a small group of the executive and go over it with your solicitor and make it workable. Our rate is lower in Nova Scotia because we are leaving out drugs. Regarding mileage I do not think there should be any question about the fact that mileage has to be considered."

The following comments on different clauses in the agreement were made by Doctor H. G. Grant. Under Clause 1 we would have to make a list of minor procedures. Clause 3, agreed upon. Clause 5, "in a hospital" should not be in there. Clause 6, since we have delegated administration to Maritime Medical Care Incorporated I think six should be struck out, and that the Minister should accept Maritime Medical Care Incorporated instead. Clause 7 is very much like Clause 6. Clause 8, administration expenses, 7%. It is only fair that we should know what we perhaps would be asked to give. One thing I would like to bring out. The Society will get 75c, which will go to the Maritime Medical Care Incorporated, and it will work out that somewhere about 90% of the minimum fees of The Medical Society of Nova Scotia will be paid the doctors.

Mr. H. S. Farquhar stated they did not consider the agreement the finished product, but that it would form the basis of discussion at this meeting, and had been drawn up using the Ontario Medical Association and the Department of Welfare of Ontario as a guide. He said that at the end of November there had been 19,631 on the old age pensioners payroll, 928 on the blind pensioners payroll. The mothers' allowance payroll included the mothers, the dependent children under sixteen, and disabled husbands, and there were 8,274 on that payroll. Total number of recipients is 28,833. The minimum payment by the Department to the Society under this agreement would be $259,497.00 a year. On the basis of the increase in recipients each month he would forecast that twelve months from now the total of 28,833 would be increased to at least 30,000. As far as the old age pensioners' list is concerned, it does not mean there are over 20,000 homes, as in quite a number of homes both man and wife are both old age pensioners, and it also includes pensioners in institutions. As far as drugs and dressings are concerned, there will be no drugs provided. The Department is quite prepared to recognize Maritime Medical Care Incorporated as the agents of The Medical Society of Nova Scotia. Clause 6 had been taken out of the Ontario agreement. It was the feeling of those charged with administration in the Department, that if the Department is going to pay a quarter of a million a year out of public monies that the Department should be in a position to know how that money is being spent. In a certain month in a year it might be found only possible to pay 60%. The Department should be in possession of sufficient information to know where a good deal of the monies they will be paying out each month is going for administrative costs, then they could

ascertain whether the administrative costs are too much and so on. If there were any further questions that he could attempt to answer he would be very glad to do so.

Doctor J. G. B. Lynch: "What can we do here to-day to finalize this?"

Doctor H. J. Martin asked when the agreement would go into effect.

Mr. H. S. Farquhar: "We have purposely left out of the agreement the date when this agreement would come into effect. Before that time if Maritime Medical Care Incorrorate 1 is to administer it for you, we would probably have to have some dealings with Mr. Macneill regarding the cards."

Doctor N. H. Gosse: "I just hurriedly read over the form of agreement to-day, and only two classes of beneficiaries were included in this agreement, the last speaker made three."

Mr. F. R. MacKinnon replied that the blind pensioners were included in the old age pensioners.

Doctor J. G. B. Lynch: "I would move that the chair appoint, a committee to go ahead and finalize the matter in the care of old age pensioners." This was seconded by Doctor A. E. Blackett. Motion carried.

The report from Maritime Medical Care Incorporated was read by Doctor N. H. Gosse, President of the Incorporation.

Doctor H. G. Grant: "I would like to know whether Maritime Medical Care Incorporated has considered the question of providing medical care for individuals. The sooner we have a comprehensive plan under way available to every one the less likely the Government would be to put into operation a scheme of Health Insurance."

Doctor N. H. Gosse stated that one of the first things was the very vexing question of mileage, and that they were now looking into a scheme of medical care in which mileage would very definitely be paid, and they were getting a lot of valuable experience on that line. So far they had been advised all along the line not to touch mileage at all. Regarding Doctor Grant's question the Maritime Medical Care Incorporated would like to see their plan in effect all over Nova Scotia, but how they were going to be able to do it was not yet quite clear. Some municipalities are taking it up. They were not just ready to go out in the field for it, but they hoped the time would come when they would be able to do so.

After some further discussion there was an intermission for afternoon tea, following which the following report was read by Doctor C. B. Stewart.

Halifax, Nova Scotia
December 9, 1949

President
Medical Society of Nova Scotia
Halifax, Nova Scotia

Dear Sir:

At the last annual meeting of The Medical Society of Nova Scotia a Committee was appointed to investigate the proposal that the services of a full-time Executive Secretary be obtained on a co-operative basis by the Medical Societies of the Maritime Provinces. The Committee consisted of Dr. R. M. MacDonald, Dr. E. F. Ross and Dr. C. B. Stewart.

Your Committee wishes to report that information was obtained from the Medical Societies of New Brunswick, Ontario, Manitoba, Saskatchewan, Alberta and British Colum-

bia with respect to their organization, appointment and duties of Secretary and other relevant matters. A review of the information and opinions obtained from these sources and consideration of the situation in Nova Scotia prompts the Committee to make the following recommendations:

Recommendation I

In view of the increasing importance and complexity of the problems facing The Medi- Society of Nova Scotia, as the organization representing the medical profession of the province, and the resulting increase in the demands upon the Executive and the part-time Secretary and in view also of the need for extension of these activities it is recommended that a full-time Medical Executive Secretary be appointed. The Committee suggests that the duties of the Secretary should include:

(a) Assistance in arrangement of Provincial and District Meetings. Although there are good Committees set up each year to deal with such meetings, in practice the tying-in of loose ends and the guiding of functions at the last minute must devolve on one person.

(b) Assistance in the editing and publishing of the Nova Scotia Medical Bulletin.

(c) Close liaison with the Society's Committee on Economics and with the Department of Health.

(d) A study of all aspects of Medical Economics and assistance to the profession in keeping up-to-date with developments in this field. The Secretary should know the situation thoroughly and be in a position to act as spokesman for the Society.

(e) Liaison with the recently established Maritime Medical Care Incorporated. The success of this prepaid medical plan depends upon full co-operation of the medical profession as well as upon the public support. The Committee feels that such liaison by a member of the medical profession would be of such value to Maritime Medical Care that this body might consider contributing to the salary of the Executive Secretary.

(f) Liaison with lay and professional bodies such as the Red Cross Society, Canadian Cancer Society and others; and with Dalhousie Medical School in furthering of post-graduate education, refresher courses, provision of speakers for District meetings, etc.

(g) Attendance at District meetings to asist personally in solution of their problems and to keep the profession informed on interesting developments within the various organizations referred to above.

(h) Assistance to the Executive in negotiation and later administration of such matters as the provision of medical care for pensioners and such other matters as from time to time may arise between the Department of Health and the profession.

Recommendation 2

It is recommended that The Medical Society of Nova Scotia investigate the possibility financing such a full-time Secretary from its own resources with possible assistance from Maritime Medical Care Incorporated and/or from the Provincial Medical Board. It is felt that an Executive Secretary serving all of the Maritime Medical Societies would not be able to devote sufficient time to the matters outlined above, and that continuation of the present system of a part-time Secretary for the Nova Scotia Society would be as satisfactory as sharing of a full-time Secretary with the other Societies.

Recommendation 3

It is recommended that the Provincial Medical Board be approached to determine whether a full-time Executive Secretary might be appointed and supported jointly by the two organizations. Several of the other provinces, especially in the West, have a very satisfactory arrangement of this nature. The duties of registration, professional discipline, assistance to doctors locating in the province, etc., are closely allied to those of an Executive Secretary of the Society alone, and it is believed that no conflict of interest need arise.

Recommendation 4

It is recommended that a careful investigation be made of possible means for financing this appointment. In fact, the feasibility of the whole matter depends upon whether the cost can be borne by the Society alone, or in co-operation with one or both of the organizations mentioned above. It has been suggested by the Honorary Secretary of The Medical Society of New Brunswick that a minimum salary of $6,000 would be required with upgrading from year to year. Costs of stenographic assistance and travel would be added to this. A budget of $9,000 to $10,000 a year would require an addition of $20 to $25 to the annual membership fee of the Society. This might decrease membership considerably unless all members of the profession were fully convinced of the desirability of this appointment. Several provinces require an annual fee from all practitioners by law, as a payment for annual registration and the right to practise. The Provincial Medical Board (or College of Physicians and Surgeons) then allocates a part of its annual income to the Medical Society, which collects no membership fees. The desirability of introducing such a system in Nova Scotia might be investigated. Several correspondence from other provinces have emphasized the importance of getting the right kind of man for the post. He must have the confidence of the profession and the public if he is to act as spokesman for the profession. He must be interested, active and up-to-date in many aspects of medical economics, medical education and medical administration. One Provincial Executive Secretary commented: "Anyone who takes on this kind of a job with a view to having a sinecure will probably be rapidly disillusioned."

It is the feeling of your Committee that if The Medical Society of Nova Scotia is not prepared to provide an adequate salary to obtain the services of a well-qualified and keenly interested individual and to provide a reasonable assurance of future continuity of employment, it would be better not to embark upon the project at all.

Respectively submitted,

C. B. Stewart, M.D., Chariman

Doctor C. B. Stewart: "I would like to make one comment. The Province of New Brunswick has decided definitely to go ahead with their plans and are now advertising for someone. I think compulsory membership in the Society is required in that Province but I have not been able to find out how it is done."

Doctor E. F. Ross: "The Medical Society of New Brunswick raised their fee to $50.00. This report has a good many aspects to it. To share a secretary with the three provinces, or four if one would bring in Newfoundland, would from our standpoint perhaps not net us very much. On the other hand, it will cost some money. We feel there are so many things happening in the day he would be very busy keeping the profession informed as to what is happening."

Doctor P. S. Cochrane: "We would have to work out some system whereby we would have compulsory membership."

Doctor H. D. O'Brien: "We are a private organization and I think we should continue to be so."

Doctor A. E. Blackett stated that the year he had been president the matter had been taken up with the Provincial Medical Board and nothing had been gained. Further negotiations might have better success.

Doctor A. D. Kelly: "They don't like the term 'compulsory membership'. The Provinces which have in effect compulsory membership are New Brunswick, where I may advise Doctor Stewart the Provincial Medical Board receives a fee which is divided into three parts, a portion for the working of the licensing agent, a portion for the New Brunswick Medical Society and a portion for the Canadian Medical Association. Saskatchewan is the next

one. I believe those are the only two in Canada. Alberta does not have compulsory membership. Manitoba is the example closest to your own. They did not come to the conclusion that it was necessary to merge the two bodies; they felt there was an advantage in retaining their individuality, so they increased their fee to $35.00 to finance a full-time secretary, and they have been able to raise their membership on a sounder basis to do it properly."

Doctor W. J. MacDonald asked how many States in the United States had compulsory membership.

Doctor A. D. Kelly replied that not very many had compulsory membership. In the United States they start with their county medical association, then the provincial.

Doctor H. G. Grant: "I would just like to say a word about this report. I think it is very excellent and I realize there is a need for a full-time secretary. I spend about two hours a day on the average for the Society, and I feel a full-time secretary could cover the four provinces provided he had a capable clerical secretary in each province. The salary should be not less than $7,500 to begin with. He really should be a district officer of the Canadian Medical Association and if so this would break down the barriers between the provinces. I think everyone will agree that trying to get these four provinces together is like trying to mix oil and water. I would like to ask Doctor Kelly what he thinks of a proposition such as that. Years ago we suggested an arrangement with the Provincial Medical Board whereby compulsory membership would be put into effect, but the suggestion was thrown out."

Dr. W. J. MacDonald: "Our individuality might be lost if we did not have our own full-time secretary. It seems to me that it will be quite an undertaking to get a man of the proper calibre and finance it. I like the way we are doing. We should assess the amount of work that is being done now and see what we would gain. We might increase the amounts paid to Doctor Grant and Mrs. Currie. The BULLETIN has been long established. We should look into the amount we are spending and see if it is adequate."

Doctor V. O. Mader: "I would like to say something in support of this report. Doctor Stewart and his committee have stated the present, made provision for the future and recommended no change at the moment. If I am asked to vote whether I support further study of this report I would personally support it."

Doctor H. J. Martin: "I would move this be left over for further study."

Doctor W. J. MacDonald: "I am in hearty support of the principle. What I am trying to do is to hold the Society together. If it becomes compulsory membership I would be outside of that. We are not giving enough support to the help we have now."

Doctor P. S. Cochrane: "That report should be published in the BULLETIN. think then it would accomplish much in the course of a year or two."

Dr. R. O Jones thought that they should look into the possibility of combining that position with the position of registrar of the Provincial Medical Board.

Doctor A. D. Kelly: "In order to get a man to spend his services over the four Maritime Provinces he would indeed need to be a superman. Your sister province of New Brunswick is going ahead; they are advertising for a man. I would suggest that each one of your representatives on the executive committee would approach the Provincial Medical Board."

Doctor C. B. Stewart: "I don't believe it was the intention of our com-

mittee that there should be a merging of the Provincial Medical Board and The Medical Society of Nova Scotia. We thought one person might be secretary to both Societies. I would like to say that I feel quite strongly that the Prepaid Medical Care might very well have a full time medical person on their staff who might act as liaison officer with the medical profession of the Province. It is really with the thought of an extension along that line that we recommend one full time man who might fill all three or any two of these positions."

Doctor H. D. O'Brien stated that he agreed with the report as it had been read and that further study should be going fairly rapidly.

Doctor H. J. Martin: "I would move that this committee make further study and bring in further recommendations incorporating the suggestions of Doctor R. O. Jones and Doctor P. S. Cochrane." This was seconded by Doctor R. O. Jones and carried.

Doctor M. E. B. Gosse advised that requests had come in from the Vancouver General Hospital, the Victoria General Hospital and medical students of Dalhousie University for the NOVA SCOTIA MEDICAL BULLETIN to be supplied either gratis or at a reduced rate. Also there was the question of reprints; Sir Lionel Whitby had asked for reprints of his paper and also that quite a large number in Ontario had asked for reprints of Sir Lionel's paper which will appear in the December BULLETIN, and she would like advice as to what procedure to follow.

Doctor H. G. Grant moved that the Executive give authority to the editor-in-chief to use her own judgment in the distribution of the NOVA SCOTIA MEDICAL BULLETIN either free or at reduced rates. This was seconded by Doctor P. S. Cochrane and carried.

Doctor V. O. Mader thought that the Society should do everything in its power to have the BULLETIN spread across the Provinces as far as is possible.

Regarding senior membership in the Canadian Medical Association Doctor H. G. Grant stated that the Lunenburg-Queens Medical Society had nominated Doctor C. B. Trites and the Colchester-East Hants Medical Society had nominated Doctor Dan Murray. Doctor P. E. Belliveau nominated Doctor S. W. Williamson. As only two could be nominated, it was decided to vote by ballot.

Regarding a registration fee of $5.00 at the annual meetings to cover entertainment expenses, it was moved by Doctor G. A. Dunn that a registration fee of $5.00 be collected at the annual meeting to cover entertainment expenses, and that it be left to the committee whether this would cover the expense of the annual dinner or not. This was seconded by Doctor S. W. Williamson and carried.

The two following letters were read by President E. F. Ross.

October 18, 1949

Dr. H. G. Grant, Secretary
Nova Scotia Medical Society
Dalhousie Public Health Service
Morris Street, Halifax

Dear Sir:

I wish to apply for membership in the Nova Scotia Medical Society and the Canadian Medical Association. In view of the fact that my husband, Dr. J. J. Quinlan is also a member and receives the Nova Scotia Medical Bulletin and the Canadian Medical Association Journal, I was wondering if there was any allowance made in membership dues in such case.

It is really nunecessary for us both to receive the journals and I would rather suscribe o some other medical publication if any allowance can be made.

Very truly yours,

(Sgd.) H. M. Holden, M.D.

135 St. Clair Avenue West
Toronto 5, Ontario
October 26th, 1949

Dr. H. G. Grant
Secretary
Medical Society of Nova Scotia
Halifax, N. S.

Dear Dr. Grant:

Re Joint Membership for Man And Wife

We are in receipt of your letter of October 19th, on the above-mentioned subject. We have a reduced rate for a doctor and his wife where both are engaged in practice and both desire membership in the Canadian Medical Association with only one Journal. Under that arrangement, the doctor pays the full membership fee to the Canadian Medical Association and his wife pays half the membership fee and does not receive the Journal. Heretofore, the fee for the wife has been $4.00, but commencing with January 1st. 1950, it will be $5.00 for the wife and $10.00 for the husband.

Yours sincerely

(Sgd.) T. C. Routley
General Secretary

Doctor S. W. Williamson moved that the fee for man and wife be one and a half. This was seconded and carried.

Doctor H. G. Grant stated that the question had been raised as to whether or not the Society should have a crest and Mr. H. P. Bernasconi had been asked to prepare some sketches, which had been received, and which were passed among the members of the executive present.

Doctor A. E. Blackett: "I would move that the chair appoint a committee to look into the matter of a suitable crest for the Society and bring in a recommendation at the next executive meeting." This was seconded by Doctor J. F. L. Woodbury and carried.

Doctor H. G. Grant announced that the result of the vote by ballot showed that Doctor Dan Murray and Doctor S. W. Williamson had been nominated to senior membership in the Canadian Medical Association. Doctor S. W. Williamson thanked the executive for the honour.

Regarding a local representative on the Committee on Public Relations of the Canadian Medical Association Doctor A. D. Kelly stated that the Executive Committee of the Canadian Medical Association had for over two years been endeavouring to find out the best way to improve relations of the lay profession and the medical profession as a whole. A Committee on Public Relations has been actively functioning now since about last May, and they have recently come to the conclusion that they needed legal help. They are at the moment looking for a public relations officer who can be employed full-time by the Canadian Medical Association. The Canadian Medical Association had sent out their letter to some two hundred men, men who had been accustomed to the necessity of keeping their eyes and ears open and

of saying and doing the right thing at the right time. He did not think that public relations was something that could be achieved at once. The lay profession wanted to be able to get a doctor at night or on Sunday when wanted. He would like to emphasize that the medical profession would attain more in public relations by attention to minor details. He thought the Society should be active in this province in public relations. The Canadian Medical Association would be very happy to have a man from Nova Scotia on their Public Relations Committee. Doctor J. G. B. Lynch had been critical of the amount of money spent during the current year. He stated they had many requests from members about how to become a doctor.

Doctor P. S. Cochrane thought that this matter might be considered by the same committee as the committee appointed to look into Doctor Stewart's report.

Doctor E. I. Glenister moved that the chair appoint a committee to look into the matter in the next few months. This was seconded by Doctor G. A. Dunn and carried.

Doctor H. G. Grant said that the Society now had as members about 85% of the active practising doctors. He would like to have the help of the president or the secretary of each branch society in obtaining 100% membership.

Doctor A. D. Kelly advised that with the exception of the Province of Quebec the percentage of 85% membership was about the average.

Doctor W. J. MacDonald stated that some years ago Doctor Grant had been around to the different branch societies with Doctor J. C. Wickwire, who was then President of the Society, and previous to that had had correspondence with the local societies.

Doctor H. G. Grant read the following form letter which he and the President thought could be sent to non-members.

"This is an invitation to you to join The Medical Soceity of Nova Scotia and the Canadian Medical Association. We need your help; we need your advice in matters of policy and also, although not so important we need your money. Never in the history of medicine in Nova Scotia was it more important than *now* that all doctors stand united.

"Take up your pen, fill out an attached form, and send along with it your cheque for $20.00.

Doctor J. J. Carroll suggested that a list of active members of each branch society be sent to the Secretary.

It was agreed that the Secretary call on each branch society next summer with a view of increasing the membership in the Society.

Doctor H. G. Grant stated that at the last meeting of the Society an extra member to the Council of the Canadian Medical Association had been appointed inadvertently, and that Doctor A. R. Morton had been the last man appointed.

Doctor V. O. Mader advised that although Doctor Morton had no special desire to stay on the Council that next year he would be President of the Halifax Medical Society, and Doctor Mader thought he had better bring that fact to the attention of the Executive.

It was agreed that the names of the Council members be placed in a hat, and the one withdrawn would be withdrawn from the Council of the Canadian Medical Association.

The following letter was read by Doctor H. G. Grant.

December 2, 1949

Dr. H. G. Grant, Secretary
Medical Society of Nova Scotia
Halifax, N. S.

Dear Doctor Grant:

The attached bill represents the charges of Mr. Frank Smith, K.C., for work done in connection with the incorporation of Maritime Medical Care. It has been long in coming and now is surprisingly small.

It will be remembered that this is part of the expense authorized by the Society, and my judgment is that it should be paid promptly.

And may I suggest Sir, something which I have no doubt you would do anyway, that you might on behalf of the Society express our thanks to Mr. Smith, for his kind interest in giving so much time and effort to getting the bill drafted and in, in time, and now for his obvious kindness in the matter of the fee. And may I further suggest without impertinence that you should tell him that you will undertake to report to the coming meeting of the executive his good offices on behalf of our effort in extending the medical care of our people.

Very Sincerely,

(Sgd.) Norman H. Gosse, M.D.

It was moved by Doctor S. W. Williamson that the Society thank Mr. Smith. This was seconded by Doctor V. O. Mader and carried.

Dr. W. A. Hewat read the following resolution which had been passed at the annual meeting at White Point in September—"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." He stated that there were a large number of men interested in the question of post-graduate study and for that reason it seemed worth while to pursue the question further. A form had been sent out to the doctors and he had interviewed a number of lay people.

A meeting of the committee composed of Doctors H. J. Martin, J. A. Webster, S. G. MacKenzie, Jr., W. G. Colwell, G. R. Douglas and himself was held in the morning. At that morning meeting it was disclosed that of the 186 replies to the circular letter only seven were not interested.

It was also shown that members of the teaching staff of the Faculty of Medicine of Dalhousie University were ready and willing to expand their post-graduate classes.

The residence clause as a requirement presents a stumbling block to the implementation of the principle of the resolution and after considerable discussion it was decided to ask The Medical Society of Nova Scotia to request the Royal College of Physicians and Surgeons to modify this clause. The modification would take the form of a system of credits as an alternate to two or more years residence in hospital and be available to men of some years (e.g. five or more) in practice with some experience in the specialty of their choice.

The credits might take the form of previous hospital training, post-graduate courses, etc. The deficit would be made up by a system of recognized prescribed courses which could be taken over a period of time. Finally,

when sufficient credits have been accumulated the person becomes eligible for examination.

Doctor W. A. Hewat moved the adoption of the report of the Committee, and that its recommendation be forwarded to the Royal College by the Secretary of the Nova Scotia Branch, rather than from the Committee, as naturally it would have more weight. Doctor A. E. Blackett seconded this, and it was adopted unanimously.

The following letter was read by Doctor H. G. Grant.

Moncton, N. B.
November, 28 1949

Dr.. G. Grant, Secretary
The Medical Society of Nova Scotia
Canadian Medical Association
Nova Scotia Division
Dalhousie Public Health Clinic
Halifax, N. S.

Dear Dr. Grant

Confirming conversation held by Mr. F. C. Cosman of the Canadian Government Railways Employees' Relief and Insurance Association and myself with you on the 23rd instant.

The Association had a schedule of fees for medical and surgical attendance which was found did not properly take care of the charges made by the doctors and surgeons, and with a view of having a new schedule put into effect, a great deal of work was done and a mimeogrpahed copy of the proposed schedule was drawn up. The Association asked the Medical Societies of the Provinces of New Brusnwick, Nova Scotia, Prince Edward Island, and Qeubec to appoint representative to attend a meeting with the Association in Moncton; and on July 22, 1948 the meeting was held in the office of the Secretary-Treasurer at Moncton, Dr. J. G. B. Lynch of Sydney represented Nova Scotia, Dr. H. E. Britton of Moncton represented New Brunswick, and Dr. W. J. P. MacMillan of Charlottetown represented Prince Edward Island. Dr. Jean Paquin of Montreal who was representative for the Province of Quebec, advised that he would not be able to attend due to the sudden illness of his son.

A general discussion took place and the Association asked that the proposed schedule be accepted by the Medical Societies of the Provinces with the understanding that the amounts as emunerated be accepted by the doctors in full for their accounts—and thus relieve the member from having to pay any additional amount.

It was explained to the representatives of the Medical Societies that the Association is not a railway affair, but is an Association controlled by the members, who must all be employees of the Canadian National Railways, and, aside from a small annual grant from the Railways, is maintained solely by the contributions of the members.

After a thorough discussion on the entire proposed schedule and a few modifications, the representatives of the Medical Societies expressed their opinion that the Schedule was quite fair.

I attended the meeting of the Medical Society of the Province of New Brunswick in September 1948 when the matter was fully discussed and, with a few further changes, it was accepted by the Medical Society of the Province of New Brunswick on a one's year trial. The Secretary-Treasurer was advised by Dr. MacMillan of Charlottetown that the Medical Society of the Province of Prince Edward Island had, at its meeting held at Charlettetown on November 1st, 1948, approved the acceptance of the proposed schedule. The Secretary-Treasurer received a communication from Dr. Lynch of Sydney, that the schedule had

been accepted by The Medical Society of the Province of Nova Scotia. It was, therefore put into effect on January 1, 1949.

We have not received any complaints from the doctors except in the Halifax area. It was due to these complaints that Mr. Cosman and I visited you on the 23rd instant and we were somewhat surprised to learn that your Medical Society had not accepted this schedule. I might add that the Association has under contract in the Halifax area twenty-two doctors who receive $4.00 a year for each member on their list. For this amount the doctors are required to give ordinary medical care—but are not required to perform any operations, look after any injuries that come under the Workmen's Compensation Act, nor for major injuries nor for the administering of anaesthetics nor any operative procedure.

The schedule as drawn up, and of which you have several copies, was arrived at after consulting various schedules set up by the different Provincial Medical Associations across Canada. The amounts set for each operative procedure were more or less an average of the fees allowed by these various Provincial Societies with a small deduction, so that the fees we propose to pay could be fitted in our financial situation. In other words, the fees listed in our Schedule are in some cases higher than those in your own Provincial Schedule and in other cases they are about equal, but in vast majority they are approximately two-thirds to three-quarters of the fees allowed under your Schedule. We felt that due to the fact payments of the amounts under this scheme are guaranteed, that they are paid in a lump sum, and there is no waiting for them, some slight reduction should therefore be in order. Furthermore, as I am sure you will appreciate, the Society only has a certain amount of money to work on each year and this money must be disbursed to the best advantage of the members of the Association, and at the same time, in such a way as to give satisfaction to the majority of the doctors who do the medical work for our members. As a result of this, we feel compelled to put a top limit to the fee schedule and this was set at $150.00. In other words, the Association feels that no matter what the operative procedure carried out, not more than $160.00 can be paid to cover it.

I might addthat the Association operates on a year to year basis that is, the money which is collected during any one year is almost completely expended during that year. No provision has ever been made for a sinking fund or a fund to accumulate a backlog. I might also add that the amounts indicated for each operative procedure are not a hard and fast set amount, that is, if the operating surgeon runs into unusual difficulties or is faced with the problem of excessive aftercare, if he would indicate this to the Association in submitting his account, due consideration would be given to it and some additional recompense arranged for. The schedule as set out is, therefore, only a guide which we feel the majority of cases will fit into.

I would be very pleased if you will have this schedule placed before your Executive Committee Meeting which is due to be held on the 10th of December next, and, in due course will advise me of any action it might comtemplate taking. I would also like to thank you for your assistance.

Yours very truly,

(Sgd.) R. J. Brown, M.D.
Chief Medical Adviser

After some discussion it was moved by Doctor R. A. Moreash and seconded by Doctor S. W. Williamson that the matter be referred to the Committee on Economics for their action. Carried.

The following letter from Mr. F. Pinfold of the Continental Casualty Company was read by Doctor H. G. Grant.

Montreal, Quebec
Novemb r 11, 1949

Dr. Ross
President Nova Scotia Medical Society
130 Oxford Street
Halifax, N.. S.

Dear Dr. Ross:

On my last trip to Halifax we discussed a Group Plan of Insurance to cover the Members of your Society. It is my intention to return to Halifax within the next month at which time I would appreciate very much if you would permit me to attend one of your executive meetings to discuss this matter further.

If this proposal is agreeable to you, would you kindly confirm it by letter.

Taking this opportunity of thanking you in advance, I remain

Yours very truly,

(Sgd.) F. Pinfold, Group Supervisor

After some discussion it was moved by Doctor H. G. Grant that the Committee on Economics would follow up the matter of a Group Plan of Insurance to cover the members of the Society and report back to the next meeting of the Executive. This was seconded by Doctor P. S. Cochrane and carried.

Doctor E. F. Ross: "At the White Point Beach meeting it was decided to unofficially interview the Premier with regard to the appointing of a medical man as a Provincial Minister of Health. This I did in November. He was very nice and approved in principle of the idea of having a doctor as Minister of Health. His opinion of Doctor Davis was very high. He said he would like very much to appoint someone like Doctor Davis in that position. I spent about half an hour with him. He is very interested in Nova Scotia. That is about the situation."

It was moved by Doctor R. O. Jones and seconded by Doctor A. R. Morton that the usual expenses to be paid to the members from out of town attending the Executive meeting. Carried.

Doctor E. F. Ross stated that it was very nice to have at the executive Doctor N. H. Gosse, the President-elect of the Canadian Medical Association, and Doctor A. D. Kelly, Assistant Secretary of the Canadian Medical Association, and they might have a word to say to the Executive with regard to the forthcoming meeting. Doctor Gosse is working hard and getting things well lined up. Doctor N. H. Gosse advised that our headache is housing. Money is coming in very satisfactorily. The Halifax Medical Society are carrying the load. The suggestion has been made that a bigger crowd than ever is planning to come to Nova Scotia and we are going to be swamped.

Doctor A. D. Kelly: "It is a pleasure to be again at the meeting of the Executive and I would like to give the greetings of Doctor Routley who was also invited to come down to this meeting and was unable to do so, and who asked me to convey his good wishes. The housing question does represent your chief problem. As far as the programme is concerned, we hope to have within the next few days all the suggestions of the speakers and topics."

Doctor W. J. MacDonald thought that the matter of salaries paid Doctor Grant and Mrs. Currie should be looked into for consideration to increases. It was decided that this matter be brought up at the next executive meeting.

Doctor E. F. Ross named the committee dealing with the agreement to be drawn up regarding the care of old age pensioners as follows: Dr. R. G. Forbes, Dr. J. J. Carroll, Dr. W. J. MacDonald and Dr. N. H. Gosse.

Meeting adjourned at 6.50 p.m.

The Doctors and the Cancer Society

At the recent annual meeting of the Nova Scotia Division of the Canadian Cancer Society a report was read which voiced depression concerning the effectiveness of the Society's educational programme and uncertainity as to any tangible results. Shortly thereafter three doctors from different parts of this country, each well qualified to speak, hastened to protest that, contrary to the opinions of the earlier speaker, the educational work done by the Cancer Society was definitely bearing fruit, and that this could be observed in the increasing numbers of patients coming to early diagnosis, and more so in the frequent visits of patients with no cancer but aware of the danger. This sort of reassurance coming from representatives of the only group qualified to give it must be a source of considerable satisfaction to those concerned in a very difficult piece of educational work whose outstanding characteristic has so often been a blind faith but very little hope. Such encouragement could be given more frequently without the smallest danger to the prestige of the doctors or the attitude of the Cancer Society towards them. In truth the doctors have very little to fear from a group which goes about preaching: "See your doctor!" and hence nothing to fear from throwing an occasional kind word toward it.

The Cancer Society is seeking co-operation from the doctors in another form. Folders have recently been sent out to all the doctors in Nova Scotia. These contain an assortment of the small booklets issued by the Society and are intended to be placed in waiting rooms where it is hoped patients, already on the doctor's doorstep, may have attention drawn to some hitherto disregarded sign or symptom. It is the hope of the Cancer Society that the doctors will look at these folders themselves before putting them to the purpose for which they are intended. Only the doctors can properly judge whether this appears to be a project likely to succeed or fail, whether it merits praise, blame or constructive criticism. Only the doctor will be qualified to say, after a fair trial period, that the idea works or does not. The Cancer Society feels that the idea deserves the "fair trial period." If after such an experiment many or most of the practising doctors of this province were to find or take time to send in some sort of report to the Cancer Society a great advantage would be gained—the direct assessment of the effectiveness of a single educational method.

M. E. B. G.

TRAUMA

Edited by ARTHUR L. MURPHY, for the Nova Scotia Branch,
The Committee on Trauma, American College of Surgeons

TWENTY-FIVE years ago the American College of Surgeons set up a "Committee on Fractures", whose aim it was to instil practitioners, not only in the College, but throughout the whole profession, with the ideals of sound fracture treatment. Finding its problems continually intermingled with other soft tissue injuries as well, the committee has evolved to the "Committee on Trauma."

Its ideals, while broader, are otherwise unchanged. They are little concerned with the development of new, intricate operative techiniques. Their interest in the surgeon specialist and the traumatic surgery section of the big city hospital is secondary. They *are* concerned with keeping ever in the minds of the general practitioner and general surgeon an awareness of the great part traumatic surgery plays in our every day professional lives. The automobile alone has brought a quadrupling of the accident rate in the past three decades. Through the height of the war years the carnage on the home front of this continent, through accident, was greater than the combined losses of Canadian and American troops on all battlefields.

Looked at from a narrower point of view, be it patient's or surgeon's, the traumatic lesion—facial scar or fracture of a long bone—perhaps stands alone in the satisfaction or suffering all may draw from the end result. Certainly there is no other group of conditions, medical or surgical in which the first treatment has as great a bearing on the outcome.

It is the feeling of many medical educationalists today that as our profession becomes broken into finer and finer specialities, each demanding increasing place in medical school curricula, that the simple, basic problems of the ever-growing traumatic field, so important to general practitioner and surgeon, are being crowded into neglect.

The Committee on Trauma of the American College of Surgeons has begotton many smaller committees throughout Canada and the United States. This *column* is an offshoot of the Nova Scotia Branch. As it grows new leaves, through ensuing months, it will not hesitate to borrow (with due credit) from publications of the parent Committee on Trauma, or from any other source. It will welcome contributions, original and as clippings. It will be happy to receive questions on problems of traumatic surgery, which it will attempt to answer with all available knowledge. It will continue for as long as material of merit is found to fill it, and for as long as the Editor of the BULLETIN finds merit in its material.

Fracture Aphorism 15.
A Small Fracture May Mean a Large Disability.

Income Tax Information

January 20, 1950

To the Secretaries of Divisions

Dear Doctor Grant:

Please find a copy of a document entitled, "Income Tax Information.'" The basis of this statement is the Memorandum on Income Tax Returns jointly sponsored by the Canadian Medical Association and the Department of National Revenue, the last issue of which was dated February 1943. The information here presented applies to income tax returns rendered by members of the medical profession in respect to the taxation year 1949. In consultation with officials of the Department of National Revenue we have endeavoured to incorporate all of the important changes which have taken place since the original memorandum was issued, and to present the facts applicable to current returns.

I would particularly call to your attention the new and somewhat complex system of calculating depreciation of capital assets, is known as "Capital Cost Allowance" and is summarized on pages 2, 3, and 4 of this document.

The other important changes relate to the claiming of expenses in relation to the operation of a motor car in medical practice. Doctors are no longer permitted to claim expenses on a mileage basis, and all claims for the operation of a motor car must be made on the basis of actual costs of operation, plus depreciation. You will note that no reference is made to any maximum figure for the cost of a motor car upon which depreciation will be allowed. Doctors replacing their present motor cars will be permitted to claim depreciation under the capital cost allowance system for the actual cost of the vehicle.

You will note further that the figure of 75% of the total mileage of a car operated partly for professional and partly for personal purposes is no longer referred to. In place of this the statement is made that only that portion of the total automobile expense incurred in earning the income from practice may be claimed as an expense, and therefore the total expense must be reduced by the portion applicable to personal use. In certain instances this will permit a doctor to claim in excess of 75% of his total motor car expenses, while in other cases the portion applicable to practice may be considerably below this figure.

It is purposed to publish this information concerning income tax returns in the March issue of the Canadian Medical Association Journal, and you are at liberty to utilize it for the notification of your members in any other manner which may be available to you.

The Committee on Income Tax of this Association has recently made representations to the responsible ministers with respect to post-graduate expenses, retirement funds, and other matters of interest to the members of the medical profession. It is not possible to estimate at this time the results of these negotiations, and returns from the medical profession for the year 1949 will be made in accordance with the provisions of the attached memorandum.

Yours faithfully,

A. D. Kelly
Assistant Secretary

February 28th, 1950

To The Secretaries of Divisions

Dear Doctor Grant:

Further to my recent letter on income tax returns by members of the medical profession, another aspect of the system of Capital Cost Allowance, applicable to 1949 *only*, has recently been drawn to my attention.

The law states that, in respect of property on hand at January 1, 1949, its capital cost is reckoned to be its undepreciated value at that date. Any proceeds of disposition in excess of that value is a capital gain and therefore non-taxable. On the other hand, should the proceeds of disposition be less than the undepreciated value at January 1, 1949, the resultant loss is deductible from income or added to the cost of the replacing asset.

For example: Dr. Jones has a motor car which prior to 1949 has been depreciated to a value of $1500. He disposes of this car to his dealer who allows him $1800 on the purchase of a new car at $2500. The $300 is capital gain and need not, in 1949, be deducted from the value of the new asset. He may apply the appropriate capital cost allowance (30%) on the full $2500 price of his new car.

Conversely, if he should receive a trade in value of only $1300 on his old car, he has sustained a loss of $200 and this amount may be added to the cost of the new car, and he would begin depreciating it in 1949 at 30% of $2700.

This information may be of some interest to doctors who during 1949 disposed of assets which are subject to Capital Cost Allowance, and you may feel free to circulate it as you see fit.

Yours faithfully,

A. D. Kelly

Assistant Secretary

INCOME TAX INFORMATION

Individuals whose income—(a) is derived from carrying on a business or profession (other than farming); (b) is derived from investments; or (c) is more than 25% derived from sources other than salary or wages, are required to pay their estimated tax by quarterly installments during such year. Each payment must be sent in with Installment Remittance Form T. 7-B Individuals. Any balance of tax is payable with interest with the T-1 General return which is due to be filed on or before April 30 of the succeeding year.

The following timetable indicates the returns required.

A. Doctors Not receiving salaries amounting to 3/4 of income:

Date Due	Forms to be Used
March 31 - - -	T.7-B Individuals
April 30 - - -	T.1-General (Note: Only doctors deriving their full professional income from salaries may use Form T.1 short.)
June 30 - - - -	T.7-B Individuals
September 30 - -	T.7-B Individuals
December 31 - -	T.7-B Individuals

B. Doctors receiving salaries amounting to 3/4 or more of income:

Date Due	Forms to be Used
April 30 - - -	T.1-General (Note: Doctors deriving their full professional income from salaries may use Form T.1 Short.)
Whenever Status is changed*	T.D-1.

Doctors who pay salaries to their own employees are required to send in Form T.-4 by the end of February each year.

For income tax purposes all salaries are net. Therefore doctors must pay tax on the total amount they receive as salary. Doctors are urged to arrange with their employers that such items as automobile expenses and medical association fees, be paid by the employer as an item of expense and not included in salary.

Dominion Income Tax Returns by Members of the Medical Profession

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Income Tax Division of the Department of National Revenue in the annual Income Tax Returns to be filed, the following matters are set out:

Income

1. There should be maintained by the doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return filed. It may be maintained on cards or in books kept for the purpose.

Expenses

2. Under the heading of expenses the following accounts should be maintained and records supported by vouchers kept available for checking purposes:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income Tax Act does not allow as a deduction a salary paid by a husband to a wife or vice versa. Such amount, if paid, is to be added back to the income);

(c) Telephone expenses;

(d) Assistant's fees;

The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given each year on Income Tax form known as Form T.4, obtainable from your District Income Tax Office;

(e) Rentals paid;

The name and address of the owner (preferably) or agent of the rented premises should be furnished (see (i));

(f) Postage and stationery;

(g) Depreciation;

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*With respect to new employer, marital status, dependents.

Effective with the taxation year 1949, a very significant change has been made with respect to the method of computing annual depreciation charges on capital equipment. This new method is termed Capital Cost Allowance and is outlined in P.C. 6385, dated December 21st, 1949. All previous information published to the profession pertaining to depreciation on both medical equipment and motor cars and on residences used for both dwelling and office purposes should be disregarded.

For the first time, definite rates of depreciation applicable to various kinds of capital assets have been defined. These rates are grouped by classes. The physician will find the following examples helpful as a first step in computing the annual depreciation on his equipment or other capital items:

Capital Item	Class	Annual Maximum Depreciation
Medical Equipment, including electrical apparatus		
(a) Instruments costing over $50 each and medical apparatus of every type	8	20%
(b) Instruments under $50 each......	12	100%
Office Furniture and Equipment...........	8	20%
Motor Car....................................	10	30%
Building (Residence used both as dwelling and office).......................................	3	5%

Replacing the previous method of charging off depreciation rateably over the estimated life of the asset, the above rates are applied as a percentage of the diminishing value each year.

An instrument acquired at a cost of $100 will be treated as follows:

Original Cost..	$100.00
Depreciation 1st year—20%.............................	20.00
Diminished Value End of 1st year........................	80.00
Depreciation 2nd year—20%.............................	16.00
Diminished Value End of 2nd Year......................	64.00
Depreciation 3rd year—20%..............................	12.80
Diminished Value End of 3rd Year.......................	51.20

(Continued until asset reduced to negligible amount).

The same procedure is applicable to the items of each class mentioned above by applying the correct percentage rate applicable.

To establish the present value of items acquired before the institution of the system of Capital Cost Allowance, the physician should deduct from the original cost the amount of depreciation already claimed.

Reference is made to T.1 General 1949, Part 4 of which sets forth the procedure to be followed. The relevant schedule is reproduced:

(1) Class Number or Kind of Asset	(2) Original Cost (Excluding Land)	(3) Total Depreciation Accumulated for Tax Purposes in Prior Years	(4) Undepreciated Cost at Beginning of Year (Col. 2 Less Col. 3)	(5) Cost of Additions During Year	(6) Proceeds from Disposals During Year	(7) Undepreciated Capital Cost Before 1949 Allowance (Col. 4 plus 5 less 6)	(8) Rate %	(9) Rate Capital Cost Allowance
A motor car purchased in 1947 for $2,500 and still on hand at end of 1949:								
10	$2,500	$1,000	$1,500	......	......	$1,500	30%	$450
A motor car purchased in 1947 for $2,500, sold in 1949 for $1,500, and replaced by purchase of a new car:								
10	$2,500	$1,000	$1,500	$2,500	$1,500	$2,500	30%	$750

If the dollar amount of the depreciation alllowance in respect of the 1949 taxation year under the new regulation is less than the allowance that would have been made under the 1948 law and practice, a doctor is permitted to deduct the dollar amount of depreciation for the 1949 taxation year equivalent to the amount which would have been permitted under the 1948 law and practice rather than under the new regulation.

When a doctor uses part of his dwelling as an office, the office premises now take a separate cost for depreciation purposes. Where one-third of the total space is occupied as office and waiting-room, the professional quarters in a $12,000 house is deemed to have a cost of $4,000. Where a doctor increases his office space in his home, he should consult his local Income Tax Office to determine the basis for depreciation.

(h) Automobile expense; (one car)

This account will include cost of license, oil, gasoline, grease, insurance, garage charges and repairs.

The capital cost allowance is restricted to the car used in professional practice and does not apply to cars for personal use.

Only that portion, of the total automobile expense, incurred in earning the income from the practice may be claimed as an expense and therefore the total expense must be reduced by the portion applicable to your personal use.*

(i) Proportional expenses of doctors practising from their residence;

(a) Owned by the doctor.

Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, capital cost allowance, and interest on mortage (name and address of mortagee to be stated);

*Please copy paragraph irom bottom of page 5.

(b) Rented by the doctor.

The rent only will be apportioned inasmuch as the owner of the premises takes care of all other expenses. The above allowances will not exceed one-third of the total house expenses or rental unless it can be shown that a greater allowance should be made for professional purposes.

(j) Sundry expenses (not otherwise classified)—The expenses charged to this account should be capable of analyses and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to your Income Tax Office. This is provided for in the Act.

The annual dues paid to governing bodies under which authority to practice is issued and membership association fees, to be recorded on the return, will be admitted as a charge. Registration fees for license to practise or other registration or entry fees, and the cost of attending postgraduate courses will not be allowed.

(k) Carrying Charges.

The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against the income from investments and not against professional income.

(l) Business tax will be allowed as an expense, but Dominion, Provincial or Municipal income tax will not be allowed.

Convention Expenses

"Effective January 1, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be admitted for Income Tax purposes against income from professional fees:

1. One Convention per year of the Canadian Medical Association.
2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.
3. One Convention per year of a Medical Society or Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated; e.g., the taxpayer should show (1) dates of the Convention; (2) the number of days present, with proof of claim supported by a certificate of attendance issued by the organization sponsoring the meetings; (3) the expenses incurred, segregating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers should be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute."

Professonal Men Under Salary Contract

3. Under the provisions of The Income Tax Act the salary paid to a doctor is taxable in full without any allowance for the deduction of automobile expenses, annual medical dues or other expenses. The employees' annual contribution to an approved Pension Plan and alimony payments, however, may be deducted from salary.

PHYSICIANS' ART SALON MOVES TO HALIFAX

The 1950 Physicians' Art Salon sponsored again by Frank W. Horner Limited, will appear for the 6th year at the Nova Scotian Hotel in Halifax. There will be displayed work in fine art, black and white photography, and color photography, created by physicians and medical undergraduates. The salon will run from June 19-23, coinciding with the C.M.A. annual meeting. The 1950 salon will retain essentially the same structure as in the past, but a few modifications have been made affecting previous first-prize winners and undergraduates.

Palette Club Formed

The salon committee announced that a Palette Club has been formed, composed of all previous first-prize winners in the three classes. Palette Club members will be withdrawn from the general competition and will be allowed to compete for special prizes in their own group. This move is made to eliminate the dominance of same artists from year to year.

Undergraduate Panel Formed

The salon committee has decided to permit all undergraduates to compete on the same basis as graduate doctors. This means elimination of a special undergraduate panel and opening the general competition to all entrants.

Salon Structure

The Physician's Art Salon is composed of three sections: fine art, monochrome photography and color photography. Exhibitors may contribute up to four entries in fine art and monochrome and up to six color transparencies. All work is judged by a panel of outstanding critics for prizes and awards of merit.

Procedure of Entry

All physicians and undergraduates who wish to exhibit work in the 1950 Physicians' Art Salon are asked to write Frank W. Horner Limited, salon sponsor. The names will be kept on a special salon mailing list so that entry forms and bulletins of general interest will be sent by first class mail. Address all inquiries to Frank W. Horner Limited, 950 St. Urbain Street, Montreal, Que.

A quantity of instruments may be purchased from Mrs. Donald Rankin, 20 Summer Street, Halifax, N.S. A list of the instruments is on file at the office of the Secretary, or prospective purchasers may communicate directly with Mrs. Rankin.

Maritime Medical Care Incorporated

(1) Maritime Medical Care.

As ex-officio member of the House of Delegates, I have recently attended the Annual Meeting of Maritime Medical Care and am pleased to report that it is very rapidly growing, and has put itself on a firm financial footing since its establishment on March 7th, 1949.

Its enrolment has grown to the present figure of over 16,000 subscribers and well over 150 groups, and I believe that new groups are being steadily added in addition to some 28,000 old age etc, pensioners, under the terms of the recent agreement with the Medical Society of Nova Scotia.

An exceptional job of work has been done by Dr. N. H. Gosse, in the organization and guidance of Maritime Medical Care, and the profession owes him a debt of gratitude in the establishment of this prepaid Medical scheme in Nova Scotia.

Maritime Medical Care was begun by The Medical Society of Nova Scotia and all the practising physicians can best show their support by becoming participating members.

(2) New agreement between The Medical Society and the Department of Health and Welfare.

This agreement has been signed and is effective March 1st, 1950. The terms have been explained to the profession in a circular letter.

One item which has caused some queston is the point at which the doctor may begin to charge mileage; this has not been laid down, but I suggest that mileage be charged after two miles from the doctor's office. This will continue in effect until the executive ratifies or changes this ruling.

I am sure that all doctors are anxious to see this scheme work. This first year will be a testing period wherein much will be learned by the profession, who administer the service, and by Maritime Medical Care, our agent. It is a new venture for the government to entrust The Medical Society with the administration of such a service, and if this scheme works, it places the Medical profession of Nova Scotia in a very favorable prosition for any future developments of a like nature.

Many pensioners seem to have the idea that complete Medical Care is being provided by the profession. The government representives have promised to try to correct this misapprehension by dissemination of more information.

(3) Annual Meeting.

As the profession is aware, the Canadian Medical Association holds its annual meeting in Halifax, in June. As a consequence the scientific meetings of our society are merged with the Canadian Medical Association, programme.

The executive of the Nova Soctia Society at its December meeting decided that we should not attempt to have business meetings during the week of the C.M.A. because of lack of time to adequately transact the many important items of business usually before us. The president was given power to decide a time; after consultation with Dr. Routley, to link up with the meetings of the other provinces, it is decided that the annual business meetings will be held on September 5th and 6th in Halifax.

E. F. Ross

Maritime Medical Care Incorporated

Report of the Board of Directors

To the Members of the House of Delegates:
Gentlemen:

In presenting this Annual Report, I experience a great deal of pleasure, in that it indicates the success of what was a very real venture of faith on the part of The Medical Society of Nova Scotia.

Our fiscal year ends with the calendar year, when our auditors must audit our books and report to us on the state of our affairs. They have only now completed their work, and this is the earliest moment that you could be called together to be given our report which is based upon theirs, and upon that of our Genreal Manager, made to the Board of Directors to-day. It will be remembered that we opened our doors for business on March 7th last, and that our first collections from subscribers became effective on April 1st. A report to the end of the year, then, covers only eight months of service of your corporation.

Financing

It will also be remembered that upon the setting up of the corporation it was decided, from the best information that we could gather, that we should establish a credit of $25,000, before we could safely start to work, and when our bankers asked about how long we expected it would take us to become soundly established, our answer, again from the experience of others, was, "About three years". It is my pleasure to report to you that our borrowing under that credit has amounted to only $6,000.00; that our year-end deficit is about one-third of what we expected; that it was incurred during our first seven months of operation, and that the last two months of the year saw the process reversed. We now have the confident expectation that deficit financing will cease within the next few months, rather than after three years. Two Thousand of our borrowed money has been paid back—not because we had a surplus, but because of easier financing.

Growth

The growth of the corporation is indicated by the fact that, whereas my report for the end of July showed only 3,169 subscibers, at December 31st we had 10,156. Our General Manager now reports that in the two months following the end of the year, that figure increased by more than 50%, to 16,146. Its growth is further indicated by the fact that where at July 31st there were 24 groups enrolled, by December 31st there were 101; two months later, 146, and that at this writing 32 new groups are in various stages of completion. Subscribers are to be found in 13 out of 16 counties.

Costs

It is not necessary to point our that costs are higher per subscriber when the numbers enrolled are small than they are when the numbers are larger, and that there comes a time with increase in numbers when the costs level off, and the cost per subscriber can be properly calculated. When that time comes, you will have opportunity to further test the efficiency of operation of your corporation by comparison of costs of other plans.

The question has been raised as to how we have been able to show such an excellent result after so short a time of operation. Reference has earlier been made to our very low promotional costs which by so much voluntary service saved us several thousand dollars. The same factors have continued to operate; we have been fortunate in the matter of our overhead - rents, etc. - and we have been fortunate in the enthusiastic service of our employees.

Growing Pains

It should not be inferred from this, however, that we have not suffered from growing pains; that we could set up an organization, employ personnel that has had no experience in such work as ours; experience sudden bursts of growth as has occured in the last few months, and not find some inefficiency in operation -- and inefficiency means loss. It is possible too, that in his efforts to keep costs down, in the earlier days of our development, our General Manager has paid salaries which in time of pressure of business, he will find to be inadequate for the positions which must be filled. You should know, however, that these problems are all recognized and that adjustments to effect their solution are constantly being considered.

Taxing Committee

The system adopted of appointing a practitioner each month to a taxing committee of three, of which one goes off each month, after three months of service, is working out very well. Their reports are what would be expected, in that the vast majority of accounts passed indicate that doctors are playing the game, but that a very small minority of the accounts show an over-servicing of patients, which, if permitted on a large scale would eventually lead to disaster. The taxing committee has up to now tended to leniency in their decisions, but intimate a tightening up on such accounts so that justice may be done to the majority. Problems have arisen from time to time which have had to be referred to the Executive. For the most part, these have involved interpretation of policy. I wish to state, however, that the Taxing Committee has rendered very excellent service.

Board and Executive

Your Executive Committee has been very active throughout the year in carrying out and interpreting the policy of the Board of Directors, and in meeting the problems which frequently arise.

Meetings of the Directors have been restricted to necessary ones only—again, because of the cost involved - while Executive meetings, which up to now have cost nothing, have been frequently held. Minutes of the Executive meetings have been sent to all members of the Board of Directors after each meeting.

Specialist and other Problems

One of the thorny problems for the Executive has arisen out of the question of Specialist Services given under our contract, and the interpretation of the scale of fees of The Medical Society of Nova Scotia has posed some problems also. Not all of these problems have been settled. The objective is to provide as full a service as possible *within the confines of the subscriber's dollar*. That dollar will go only so far in Medical Care as in other things, but it is conceivable that as we become more firmly established, techniques

will be devised by which it may be stretched to greater coverage in Medical Service than is now possible. It must be recorded, however, that where at first the difficulties were great, a spirit of co-operation has prevailed, and that although many differences remain, we are constantly endeavouring to have them composed.

Reserves

Up to now, doctors' accounts have been paid at 100c on the dollar—the only Plan in Canada, we believe, that is doing this. The question has now been raised as to whether the time is not now come when we should begin to set up reserves in the corporation to tender that stability in operation which most Plans operating elsewhere have found to be necessary. It has been suggested that we should begin to pay 90c on the dollar of submitted accounts, and that a reserve should be begun. A discussion of this subject among other Plans in November last, showed some difference of opinion as to the ultimate size of such reserve, the bulk of the opinion favouring the figure of Five Dollars per subscriber, built up over a period of years. You will be asked to discuss this matter. Your Executive discussed it some time ago and deferred action.

Overall Canadian Plan

It is my pleasure to inform you that at a meeting of all the medically-sponsored Plans of Canada, held in Toronto in November last, further consideration was given to the seeking of incorporation for a new body which would operate on the National level, and of which each subscribing medically-sponsored Plan would be a part. The way to this is not entirely free of difficulties. It was, however, left to a committee to explore, with the understanding that if the legislative difficulties proved to be hurdles which it were not wise to take, the end sought would be encompassed by agreement among the Plans themselves, whereby the Plan of one province would be recognized and serviced when it showed up in another. Actually, there is no difficulty for our subscribers now, in that payment of their bills, according to our scale, is provided for in any province, but on the basis of reimbursement. It is suggested that the new arrangement would provide that service be provided by the Plan of the province in which the subscriber became ill, and that Plan would effect adjustment with the home Plan. The committee is a good one, and we shall hear more about it in June.

Welfare Plan

Though not part of any report of the Year 1949, it is felt that you should be brought up to the minute on another matter which affects this corporation and the profession of Medicine.

Agreement has been entered into between your corporation and The Medical Society of Nova Scotia, by which we have been designated the agent of The Medical Society, for the purpose of administering the Plan of Medical Care of the Department of Welfare of the Province of Nova Scotia. This Plan, as you know, gives medical care in the home and in the doctor's office to the three groups coming under: Old Age Pensions, Mother's Allowance, and The Blind. In the ordinary sense, it does not provide drugs, but such emergency things as a doctor may ordinarily carry or use in his office are included.

It had been planned to begin the service March 1st—*and indeed it did begin on that date*—but some delay in the signing of the Agreement as between The Medical Society and Welfare, which, in turn, seemed to have been occasioned by delay in obtaining a certain Order-In-Council, held up the issuing of the final advice to doctors by The Medical Society. We, ourselves, were so flooded with requests for information about it from different parts of the province, stimulated, in turn, by requests from beneficaries under the Plan, that, on the assurance of the Department of Welfare that the cheque would be forthcoming, we released our letter and statement to the doctors, so that they might be able to give intelligent answers to the questions asked, and to give the service which those people had been told to expect. It was done on a "Gentleman's agreement" up to that point, but I am informed to-day that the Order-in-Council has now been passed and so both our faith and our work have been justified.

Insofar as the funds will provide, doctors' bills for service under this Welfare Plan will be for *such service in the home and doctors' offices as is ordinarily given and billed for* in the respective communities, and payment will be on the basis of the minimum schedule of fees of The Medical Society of Nova Scotia. What proportion of the bills the fund will be able to meet, we do not know. Since the income is fixed, the payments must depend upon the amount of service given. You will appreciate, however, that as The Medical Society of Nova Scotia will be anxious to establish the fact that it can give good service under a governmental scheme, your corporation will do its part with the same economy and care as that which is exercised in those affairs which are its primary concern and raison d'être.

The number of beneficiaries under this Plan is about 28,000 and it increases each year. Our own expansion, with this, indicates that in the very near future we shall have under partial or complete coverage 50,000 people. Few people, except those who are inside, can appreciate what that rapidity of expansion means in an office. It will not be surprising therefore that, in anticipation of this, we, sometime ago, authorized the installation of I.B.M. equipment to cope with this extra work on an efficient and, we hope, more economical basis.

It is our understanding that some embarrassment has arisen in another connection; to wit—the *extent* of the medical service provided under the Act. This embarrassment has been brought about, because some of the beneficiaries have indicated to doctors about the province their belief that they had been provided with a *complete* service, and I have personally met in hospital, beneficiaries who thought they were covered there as well as in their homes. I do not know what the original announcement contained, or conveyed, but either it was not as clear as it might have been, or its interpretation was wrong. We ear now informed that a new statement is forthcoming, which will clearly represent the facts of the case.

Conclusion

In conclusion, I would express our appreciation of the very fine service and co-operation rendered by our staff. They have been, and are, keenly interested people, and have done a fine job. Your thanks are due to

our Taxing Committees who have been doing an unenviable job very conscientiously; and excluding any personal connection, or reference, to those members of the Executive also—Honourable Mr. Walker, Dr. Corston, and, since the White Point meeting, Dr. MacRae—who have given many long hours to meetings on your corporation's problems and affairs.

Respectfully submitted,

On behalf of the Board of Direcors,
Norman H. Gosse, M.D.
President

Halifax, N. S.
March 7, 1950.