The Part of the Practising Physician in Office and Community *

H. B. ROSS, M.D.,
Halifax, N. S.

THE past fifty years have brought sweeping changes in the role of the Practising Physician in his home community. Whereas then, he gave most of his time to the treatment of disease once it had occurred—to-day a great deal of his effort must be devoted to the prevention of these diseases where possible, and increased attention to early diagnosis.

He used to treat diphtheria and its complications,—now he immunizes against it. He used to watch in despair the ravages of tuberculosis—but now in co-operation with the Public Health Team, an early diagnosis is made, and in a short while a useful citizen and his healed pulmonary lesion return to the community. And *then*, having prevented one disease, made an early diagnosis in another he may turn his attention to a problem in Rehabilitation. In this latter field his part may not be active but he must know how to refer his patients to agencies that have undertaken Rehabilitation Programmes.

And what does the physician feel about Child and Maternal Health? Well—I think most of their feelings are similar to mine. That the eclamptic mother, the undiagnosed diabetic pregnant woman, the threatened abortion, the anaemic and malnourished (but not necessarily poor) maternity case, the stillborn infant and the three lb. premature are examples of "too little and too late." But in this field the problems are so varied and his time limited that he needs and should seek assistance. And this assistance must encompass not only education directed toward the prenatal period, but also the PRE-CONCEPTION time in the lives of our young women.

I think too, that he would agree with me if I proposed Five Basic Concepts of Good Child and Maternal Care. May I hasten before such an audience to say that they are given also as the *Five Levels of Prevention* in a recently published *Textbook of Preventive Medicine.*

(1) Health promotion:—Office and group teaching.
(2) Specific protection:—Immunization.
(3) Early recognition and prompt treatment of all disease.
(4) Limitation of disability:—(a) skilled obstetrics.
(b) recognition of complications.
(5) Rehabilitation:—(a) care of the mother in post-partum period.
(b) recovery to full activity and family duties.

Let us take one of these concepts that perhaps concern us more to-day here at this meeting.

Health Promotion:

The physician of 1956 finds himself defining health as "the state of physical, mental and social well-being; not merely the absence of disease and infirmity."

*Presented in the Symposium on Child and Maternal Health, Canadian Public Health Association, Atlantic Branch, November 9th and 10th, 1955, at Kentville, N. S.

And if he accepts this definition, he must then be prepared to guide and counsel in his office, in the home or in a clinic more and more mothers and children generally in the past regarded as neurotics, chronic complainers, behaviour problems and "little brats".

If these problems are dealt with to public satisfaction, perhaps we might hope to make greater progress in our Maternal and Child Care Programmes. Because it is only by seeing larger numbers of our pregnant women and supposedly well babies more often, that we can hope to correct the conditions that are contributing to our relatively poor (compared to some countries) Infant Mortality Rate.

Gone or rapidly disappearing are the physicians who were like the old paediatrician who gave his little patients castor oil when they were brought to him over trivial matters. When queried by his young associate, he replied with a snort, "That's the best way I know of keeping my office clear of well-children."

My conception of the solution to the problem of health promotion is that the physician become more of a leader and director in the community in the field of Health Promotion. To do this, we need more workers in this field. Not only to work with him, but to work beside him. We need to continue to sell the advantages and benefits of Well Baby and Maternal Care. Where there is a scarcity of physicians, they can pool their time and resources by the use of Group Teaching or Well Baby Clinics using rotation of duty. We are seeing a great demand in the larger population areas for this sort of Group Teaching as illustrated by the formation of Diabetic, Paraplegic, Cerebral Palsy and Mental Retardation Societies.

In closing may I stress the importance of nutrition in relation to Child and Maternal Health. Investigation is showing that children falling victims to Tb and Rheumatic Fever are frequently in negative nitrogen balance and a well known piece of work has shown that the adequate nutrition group of mothers have a much lower premature and stillbirth rate. But good eating habits go back to our childhood years.

And that brings me back to an earlier point, that our attack on this problem under discussion to-day, must begin before *conception* takes place.

BURSARY FOR TRAINING IN CLINICAL PATHOLOGY.

A Bursary covering training in Clinical Pathology leading up to certification in this subject will be available commencing in July, 1956. For further information interested parties are asked to write the Director of Radiological and Laboratory Services, Department of Public Health, Provincial Building Hollis Street, Halifax, N. S.

Tumours of the Parotid

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Department of Surgery, Victoria General Hospital,
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TO the surgeon approaching any tumour, the first broad decision to be made, on which he will base his treatment, is whether it be benign or malignant. Sometimes he will make this diagnosis on clinical findings, content to accept the pathologist's confirmation on examination of the operative specimen. On occasion he will proceed surgically only after histological study of biopsy specimen. More often he will want examination of frozen section during operation to confirm the gross pathology, and indicate the proper procedure.

In approaching tumours of the parotid he often finds clinical judgment uncertain; and pathological study, far from lending him the almost mathematical surety he likes to demand of it, may add to his confusion.

By far the commonest of parotid growths is the "mixed tumour." Occurring in all the salivary glands, it is seen approximately nine times more frequently in the parotid. Its etiology and its true nature are obscure. Some investigators maintain that the term, mixed tumour, is incorrect; that the entity embraces a group of tumours. Cartilaginous-like material seen in many such growths has been called true cartilage; it has been called pseudo-cartilage. The epithelial elements may closely resemble adenocarcinoma or may be strewn throughout the mucoid stroma in the form of cords, again with a malignant appearance. Ewing called the mixed tumour malignant. Even the most ardent proponent of its benignity will admit its inherent tendency to recur, within the parotid, and even to metastasize, though rarely, in the immediately adjacent lymph nodes.

Without risking our poor surgical opinions further in this argumentative field, we can say, from basic histological study and clinical experience that: (a) The tumour is embryonic in its origin and hence must often present a confusing histological picture. (b) It does undergo, uncommonly, degeneration into frank carcinoma. (c) It is sometimes difficult to distinguish from primary malignant tumours.

The embryonic origin of the mixed cell tumour is in keeping with its multicentricity throughout the gland. This offers a logical explanation for the recurrences which take place, and which have been blamed, often wrongly, on incomplete surgical removal. Experimental work on dogs has shown that mixed tumours may be produced by tying off the parotid duct. The reason for this is unknown, but it does offer another possible explanation of recurrence. When any portion of the gland is removed at operation minute ducts are tied. Recurrence may result from secretions, thus dammed back, acting on the deeper and more posterior portions of the gland. The experiments also offer an explanation for the phenomenon of mixed tumour combined with widespread infection through the parotid which is seen not infrequently. May it be that a partial obstruction of the parotid duct is responsible for the simultaneous onset of infection and neoplasm? Certainly, patients with mixed tumours often give a history of a swelling which increase with increased salivation, subsided and recurred, leading to the onset of the true tumour.

The mixed tumour frequently undergoes cystic degeneration, again th result, presumably, of blockage within the ducts. It may on occasion disappea altogether, and spontaneous cures have been reported by reliable investigator Considering the nature of the growth, this seems unlikely. More likely i that the cyst absorbs or is discharged into another duct, and that the origina growth lies dormant and goes unnoticed for a long time.

With such confusion in the pathology of these tumours, the surgeon mus lean heavily on his clinical findings. Here, too, uncertainty may arise in th first moments of his examination when he is unsure as to whether the sma nodule beneath the angle of the mandible is in the parotid at all, or is a solitar lymph node. Remembering that the normal gland extends well below the angl of the mandible, and sweeps forward beneath it for at least a centimeter, wi help him in this. If the gland be grossly involved in a hard, fixed, irregula tumour, or if there be a facial paralysis, from involvement of the facial nerv he will know he is dealing with a frank carcinoma. If, on the other hand, the is pain in the side of the face, from pressure on the great auricular nerve, h will be no wiser, because either mixed tumour or malignancy may cause thi If the tumour be freely movable with the gland, but almost stony hard, it ma be mixed tumour, or it may be carcinoma. If it be soft and diffuse, it ma again be either type of growth, changed in character by degeneration or secon ary infection.

Age incidence will be of little help to him because, while the mixed tumo is most common between twenty and forty years and the carcinoma rath later, either may occur throughout the whole life span.

The next diagnostic step must be the direct visualization of the gland f a study of its gross pathology. Removal of a portion of the tumour for biops or, if it be small, removal of the whole tumour through a minute incision, a both to be condemned. Biopy will show the characteristics of the tiss removed only, and not those of adjacent tissue which may be quite differen Local removal of the tumour alone, through an inadequate exposure, is like to be an incomplete removal. Moreover, there is a great risk of damagi a branch of the facial nerve. With complete operative exposure of the glan the surgeon is still not free of his dilemma. A mixed tumour may present thick hard capsule, but it may grow within a scarcely discernible one. Froz sections made from multiple areas of the tumour, at operation, may be st inconclusive.

Because of the difficulties of diagnosis and because of the tendency of t mixed tumour to recur, it follows that there is only one good surgical treatme for parotid tumours, whatever their pathology. That is, complete surgi removal of the parotid gland.

We will admit one exception to this: the small tumour, sitting on t of the gland, well encapsulated, which can be removed without incising deep into gland substance. If this is shown to be benign, the operation may curative; and if there is recurrence, further surgery has at least not been ma more hazardous by the first operation.

The mixed tumour is highly resistant to x-radiation which, by fibros can only complicate the operative treatment that will surely follow it.

carcinoma, when there is doubt about the completeness of surgical removal, radiation has a secondary place.

Twenty years ago when it was believed and taught that complete removal of the parotid meant inevitable damage to the facial nerve, and the resultant distressing deformity, there was good reason for the conservative local removal of simple tumours in this area. Knowing to-day, as we do, that with careful dissection, the gland can be completely removed without nerve damage, there is no excuse for a lesser procedure.

It is to the everlasting shame of us in surgery who operated on these tumours in earlier years, injured facial nerves too frequently, because we "knew" injury could not be avoided, that it was from the anatomy laboratory and the cadaver, the conviction came that we were wrong. Whatever its few variations, the facial nerve runs, not through the gland, as was once believed, but between its outer and deep lobes, dividing into upper and lower branches as it might about the shank of an upended collar button. With sufficient patience, the whole outer lobe can be removed *en masse*, and the deep lobe, if necessary, piecemeal, without nerve injury. Through experience, surgery can give one small lesson to anatomy and physiology. Although anatomists demonstrate many anastomoses between the minute terminal divisions of the nerve, suggesting an overlapping of nerve supply, surgical experience shows that the cutting of even one of the finest of these will result in some area of permanent paralysis.

The incision extends vertically down in front of the ear, behind the angle of the jaw, and then curves easily forward to follow beneath the mandible far enough to make a flap that can be turned forward exposing the whole gland. A short arm of this incision, up and back, from beneath the lobe of the ear facilitates dissection of the nerve as it enters the gland. Scarring is minimal and the only deformity is the hollow behind the angle of the mandible from the removal of the gland. We have tried all methods of dissecting the nerve out: picking the fibres up anteriorly and following them back; picking up the superior branch as it runs half an inch above the parotid duct, and the inferior branch as it crosses the posterior facial vein just after the vein passes beneath the parotid. We have learned that the best method is to pick the nerve up as it comes out of the foramen, dissect it through to its point of division about the parotid stock, and to follow its branches forward all the way. The operation does not require any great surgical dexterity; it does demand gentleness and infinite patience. If the nerve be handled roughly it will cease to function, temporarily, and the surgeon is then captain of a compassless ship in dense fog, off a rocky shore.

Most important member of the surgical team is the second assistant. With the patient's full profile undraped, it is his job to watch every moment for muscular twitching, indicative of nerve irritation. I have long since discarded the electric nerve stimulator as an inadequate and often misleading instrument. All tissue to be cut is picked up in minute portions between fine mosquito forceps which are clamped only after gentle squeezing has produced no response on the face. If the whole operation is carried out in this way, no nerve damage can be done, and with a good surgical knowledge of the area, it need not be too lengthy.

A good end result in operations on mixed tumour demands that the gland

be completely removed and that the facial muscles show complete function or, at worse, minute areas of temporary impairment.

If the tumour be frankly carcinomatous, the operation may be combined with a radical dissection of the same side of the neck. If the facial nerve be involved in growth, it must be sacrificed. It may be possible to resect the involved portion and anastomose the ends. If not, results from fascial sling operations for restoration of facial symmetry, while not ideal, are fairly satisfactory. By fixing the slings into the belly, rather than the fascia, of the temporal muscle, slight movement of the lips and angle of the mouth can be gotten.

Summary

Accurate clinical and pathological diagnosis of parotid tumours is difficult. The mixed tumour may be multicentric in origin. Duct obstruction may be a factor in its production. In all parotid tumours, total excision of the gland is the right treatment. This operation can be done without facial nerve damage.

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

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., March 7, 1956, at 4.00 p.m

The President called the meeting to order.

Present were: Dr. R. O. Jones, Halifax, President; Dr. J R. McCleave, Digby, First Vice-President; Dr. A. L. Murphy, Halifax, Second Vice-President; Dr. C. H. Young, Dartmouth, Treasurer; Dr. M. R. Macdonald, Halifax, Secretary; Dr. C. L. Gosse, Halifax, Dr. D. I. Rice, Halifax, Halifax Medical Society; Dr. Arthur L. Sutherland, Sydney, Dr. Arthur W. Ormiston, Sydney, Cape Breton Medical Society· Dr. J. A. MacCormick, Antigonish, Antigonish-Guysborough Medical Society; Dr. G. Ritchie Douglas, New Glasgow, Pictou County Medical Society; Dr. P. R. Little, Truro, Colchester-East Hants Medical Society; Dr J. P. McGrath, Kentville, Valley Medical Society; Dr. Samuel Marcus, Bridgewater, Lunenburg-Queens Medical Society; Dr. D. F. Macdonald, Yarmouth, Western Counties Medical Society; Dr. A. G. MacLeod, Dartmouth, General Practitioners Association. Absent was the representative of the Cumberland County Medical Society.

1. Reading of the Minutes of the last Executive Meeting.

Dr. C. L. Gosse moved Dr. Arthur W. Ormiston seconded

That the minutes of the last executive meeting in Amherst, September, 1955, which had been circularized to the executive members, be taken as read. Carried.

2. **The New Constitution and By-Laws** were approved by the Governor in-Council, December 7, 1955.

Dr. D. F. Macdonald moved Dr. C. L. Gosse seconded

That the New Constitution be proclaimed immediately and that the various sections of it become effective as applicable. The whole constitution to be effective at the time of the next Annual Meeting. Carried.

3. **Annual Meeting for 1956.**

The Annual Meeting will be held at the Nova Scotian Hotel on September 4, 5, 6, and 7, 1956. The Halifax Medical Society is the host society and the following members were appointed a Committee on Arrangements to work with the President:

Dr. E. P. Nonamaker—Programme
Dr. A. W. Titus —Housing
Dr. W. A. Murray —Entertainment
Dr. A. L. Murphy —Member.

The Secretary reported that because of previous hotel bookings the meeting could not be held in Halifax, September 11th-14th.

After a full and complete discussion regarding the division of time for the scientific and business sections of the programme, it was

Moved by Dr. A. L. Murphy Seconded by Dr. J. R. McCleave

That the scientific programme be confined to the contributions of the members of The Canadian Medical Association team, at the meeting in 1956. Carried.

In regard to a choice of speakers and subjects the Programme Committee was asked to check with the Refresher Course Committee in order to avoid duplication, and submit any ideas to the Canadian Medical Association Secretary re choice of speakers and subjects

Committee on Annual Meeting.

The President reported that due to unforeseen circumstances, it had been difficult to get this Committee together, but various ideas regarding the holding of the Annual Meeting were discussed Time, location, attendance of exhibits, accommodation of The Canadian Medical Association Team, also the possibility of holding the meeting in conjunction with the Dalhousie Refresher Course were discussed

Moved by Dr. C. L. Gosse Seconded by Dr. J. P. McGrath

That the question of the time of holding annual meetings be brought up at the next annual meeting for discussion. Carried.

4. **Appointment of the House of Delegates for Maritime Medical Care Incorporated.**

On motion the following members were appointed to the House of Delegates of Maritime Medical Care Incorporated:

Dr. F. Murray Fraser, Halifax; Dr. A. G. MacLeod, Dartmouth; Dr. H. B. Whitman, Westville; Dr. R. F. Ross, Truro; Dr G. D Donaldson, Mahone Bay; Dr. L. A. MacLeod, Liverpool; Dr J. B. MacDonald, Stellarton; Dr. Arthur L. Sutherland, Sydney; Dr. D. M. MacRae, Halifax; Dr. J. F. L. Woodbury, Halifax; Dr. R. A. Moreash, Berwick; Carmen N. MacIntosh, Antigonish; Dr. H. R. Peel, Truro; Dr. J. A. Langille, Amherst; Dr. D. F. Macdonald, Yarmouth; Dr. G. C. Macdonald, Sydney.

A letter was read from the General Manager of Maritime Medical Care Incorporated pointing out that Dr. A. G. MacLeod, Dr. F. M. Fraser, Dr. H. B. Whitman and Dr. R. F. Ross were appointed to the Board of Directors last year and each had one more year to serve.

5. **Advisory Committee on Health Insurance.**

Dr. D. M. MacRae presented a verbal report on the activities of this Committee. He stated that numerous meetings and conferences were held, and that many important aspects of the Health Insurance question were studied. He did suggest that his Committee would like some clarification of the terms of reference of the Committee. Considerable discussion took place in regard to this which culminated in the following motion.

Moved by Dr. D. I. Rice Seconded by Dr. D. F. Macdonald

That this Committee be empowered to see the Deputy Minister of Health with the thought in mind, that if feasible,this Committee act as an official liaison committee with the Department of Health, in all matters relating to affairs affecting the members of TheMedical Society of Nova Scotia and The Department of Health. Carried.

6. **Medical Economics Committee.**

Dr. H. J. Devereux reported on a meeting of the Medical Economics Committee held March 7, 1956. On recommendation of this Committee the following motions were passed.

Moved by Dr. A. L. Sutherland Seconded by Dr. D. I. Rice

That the Workmen's Compensation Board meet with the Workmen's Compensation Board Committee in an attempt to have the Board increase their schedule of fees, to a reasonable standard. Carried.

Moved by Dr. D. F. Macdonald Seconded by Dr. C. H. Young

That in regard to the $50 fee allowed for surgical care in hospital for recipients under the Provincial Welfare Plan, that the fee be apportioned as follows—$30 to be paid to the Surgeon, $10 to the Assistant Surgeon and $10 to the Anaesthetist, and that this recommendation be sent to Maritime Medical Care Incorporated. Carried.

Moved by Dr. A. W. Ormiston Seconded by Dr. J. A. MacCormick

That the Committee on Tariffs be asked to study the D. V. A. Schedule of Fees, considering the individual items in an attempt to bring them in line with the Nova Scotia Schedule of Fees, and that this Committee report to the Medical Economics Committee on or before April 13th, at which time it will be presented to the National Committee on Medical Economics. Carried.

Moved by Dr. A. L. Sutherland Seconded by Dr. D. F. Macdonald

That the report of the Medical Economics Committee be accepted. Carried.

7 **Correspondence.**

(a) A letter was read from Doctor C G Harries, New Glasgow, regarding a visit he paid to the home for mentally handicapped children, operated by Mr H H Clark Mr. Clark has asked for the endorsement of The Society for his home at a previous meeting.

Moved by Dr. A. L. Murphy Seconded by Dr. P. R. Little

That an advertisement for Mr. Clark's Home be inserted in the Nova Scotia Medical Bulletin, free of charge, for three issues. Carried

(b) Letter from Doctor C. B. Stewart, member of the Public Health Committee, regarding the proposed plans for distribution of the Salk Polio Vaccine for 1956.

After considerable discussion the Secretary was instructed to report the discussion to Doctor Stewart, especially in regard to the feasibility of making some vaccine available for the use of private practitioners.

(c) A letter was read from Doctor H. L. Scammell, Registrar of the Provincial Medical Board, regarding the allegation of a lay person travelling throughout the Province, practising medicine without a license.

The letter was ordered filed.

(d) A letter was read from Doctor A. D. Kelly, Secretary The Canadian Medical Association, regarding the proposals on health and hospital insurance submitted to the Provincial Ministers of Health at the Federal-Provincial Conference

8. The following publications were tabled:

(a) You and The Canadian Medical Association—C.M.A.

(b) Basis of Approval of Hospital for the Training of Internes in Canada—C.M.A.

(c) Code of Ethics—C.M.A.

9. **Interim Report of the Committee on Tariffs.**

Doctor E F. Ross presented the following interim report of the Committee on Tariffs:

"1. The nucleus committee believe that there should be a general practitioner and a specialist scale of fees.

"2. The general practitioner and specialist groups were contacted and invited to submit schedules. This was done through organizations when they existed or through individual doctors, generally the Head of the particular university department. These have been received with some exceptions. They have been reviewed by Dr. J. W. Reid and myself; we are of the opinion that they are reasonable and acceptable. We suggest that the proposed schedules be published in the Bulletin several months before the annual meeting to allow time for study. Your nucleus committee consider that medical fees have not advanced with the cost of living.

"3. The matter of proportionate worth of the pre-operative, operative, assistant, and post-operative elements of the total fee for a surgical procedure was referred to the Tariff committee. We have discussed this matter ourselves and with practising surgeons without forming an opinion."

Moved by Dr. J. P. McGrath Seconded by Dr. J. R. McCleave That this report be received. Carried.

10. Doctor R. O. Jones, President, announced that he had appointed:

(a) Dr. N. B. Trask to replace the late Dr. P. O. Hebb on the Committee on Tariffs.

(b) Dr. W. A. MacQuarrie, Trenton, to replace the late Dr. C. E. Stuart, on the Industrial Health Committee.

11. **Committee on Full-time Secretary.**

Doctor E. F. Ross presented a report of the activities of the Committee for a full-time Secretary. He felt that his Committee should be given clarification of its terms of reference in relation to the following:

(1) How far they were empowered to go in securing a full-time secretary.

(2) The amount of the minimum and maximum salary that could be offered. A tentative suggestion of his committee was $10,000 plus pension going to $12,000 with pension in four years.

(3) Advertising was not thought to be practical but rather that a list of names be compiled and that the best be selected and approached to accept the position.

(4) That the Committee felt that the membership fees should be increased to a total of $75 so that money would be available when a secretary was procured.

There was considerable discussion regarding the question of procuring

the services of a full-time secretary, and the work of the Committee, following which:

Moved by Dr. C. L. Gosse Seconded by Dr. A. L. Murphy

That the Committee be enlarged by three more members and that they be empowered to employ a fulltime secretary, up to a salary of $15,000, and that this Executive will back them up in any reasonable decision. Carried.

12. **Annual Membership Fee.**

Considerable discussion took place in regard to the membership fee for 1956, in view of the revenue needed to pay a full-time secretary.

Moved by Dr. J. A. MacCormick Seconded by Dr. J. P. McGarth

That the conjoint fee including the levy for post-graduate work be increased to $75, $50 for The Medical Society of Nova Scotia, $20 for The Canadian Medical Association, $5 for the Post-Graduate levy. Carried.

It was recommended that a covering letter be sent out with the bills for membership, explaining the purpose in increasing the fees.

The Secretary and Treasurer were authorized to grade the fees for certain classification of members in line with The Canadian Medical Association gradation.

13. **Interim Report of the Committee studying the relationship between The Medical Society of Nova Scotia and Maritime Medical Care Incorporated.**

Doctor J. F. L. Woodbury, Chairman of this Committee, submitted the following interim report:

"Your Committee has met several times. It has invited opinions from former Presidents of Maritime Medical Care, from the Administrative and Medical Staff of that Corporation, from such special groups as Surgeons, Internists and General Practitioners, and from local Branches of the Nova Scotia Medical Society.

"A considerable volume of suggestions has come from these groups, and this has been discussed. No decisions have been taken as to what should be recommended to the Society to alter relationships with the Corporation. It is estimated that there is a further month or two of work before the final Report of this Committee can go forward."

14. **Committee on Study of the Diet Manual issued by the Department of Health.**

Doctor R. M. MacDonald, Chairman, reported that the following members were appointed members of his Committee:

Dr. J. C. Wickwire, Liverpool; Dr. J. E. MacDonell, Antigonish; Dr. E. D. MacArthur, Berwick; Dr. J. A. Webster, Yarmouth.

15. **Group Disability Insurance Plan.**

The Secretary reported on the Group Disability Insurance Plan that had been circularized to the members of The Society by Blaker, Hearns and Company, Westmount, Quebec. After considerable discussion it was—

Moved by Dr. J. P. McGrath Seconded by Dr. A. L. Sutherland

That the Executive approve of this Group Disability Plan as the official plan for The Medical Society of Nova Scotia. Carried.

16. **Group Life Insurance Plan.**

A group Life Insurance Plan as submitted by Blaker, Hearns and Company was tabled.

After discussion, it was decided to take no action in regard to this plan.

17. **C.M.A. House.**

It was reported that all Divisions of The Canadian Medical Association were asked if they would like to present gifts for the new headquarters of The Canadian Medical Association in Toronto. It was agreed to supply a plaque bearing the crest of the Nova Scotia Division to The Canadian Medical Association at a cost of $25 to $30. It was also agreed to present them with a framed copy of the Armorial Bearings.

18. Approval was given for the attendance of the Secretary at the Midwinter Meeting of Divisional Secretaries and for payment of expenses in line with the pooling arrangements of The Canadian Medical Association.

19. **Mediation Committee.**

Considerable discussion took place in regard to the disposal of complaints of patients against physicians. It was agreed that such complaints should be referred to the Registrar of the Provincial Medical Board, and no action was taken on the formation of a Mediation Committee.

20. A letter of appreciation was received from Doctor F. L. Hill on the occasion of him being made a Senior Member of The Medical Society of Nova Scotia.

21. **Nominations for Senior Memberships in The Canadian Medical Association from the Nova Scotia Division.**

Doctor G. H. Murphy, Halifax, was named the nominee from the Nova Scotia Division.

22. **Nominations for Senior Membership in The Medical Society of Nova Scotia.**

Doctor P. S. Campbell, Halifax, and Doctor M. R. Elliott, Wolfville, were nominated for Senior Membership in The Medical Society of Nova Scotia.

23. **Honorary and Senior Membership in Nova Scotia Division.**

Because of the new classification for Honorary and Senior Membership, under the new Constitution, it was—

Moved by Dr. C. L. Gosse ,Seconded by Dr. C. H. Young

That the present honorary members of the Nova Scotia Division who are eligible for Senior Membership under the new constitution be transferred to this classification. Carried.

On motion the meeting adjourned at 10.30 p. m.

M. R. MACDONALD,
Secretary.

Golden Jubilee
Saint Joseph's Hospital *
1955

Its First Medical Staff, 1902, recalled by its only survivor,
George H. Murphy, M.D., F.R.C.S., L.L.D.

The old order changeth giving place to new,
And God fulfills Himself in many ways.
—Tennyson.

WHILE acknowledging the inevitable changes wrought in all human progress with the passing of time, it is not of this I write. I shall not be unmindful, however, that growth depends upon the good seed that is sown and the character and cultivation of the soil in which it is planted. God will take care of the harvest. Such, I believe, was the seed and the soil of a great undertaking that, in 1902, produced St. Joseph's hospital. If you would know of its growth, look around you. Surely God has taken care of the harvest!

And now to my promise to contribute a bit of writing on the Hospital's Attending Medical Staff at its beginning and earlier years. I think the good-hearted Sister suggested I might make any commentaries I thought appropriate in my narration. But though I shall stretch my memory to the sticking point, much subject matter will escape in the haze of the years.

I start my subject by quoting a passage from an article I wrote some years ago for the Nova Scotia Medical Bulletin. It fits now, I think, as a sort of keynote to my theme; for it concerns one who was the pillar and guide of the Medical Staff in its first years, and indeed to his all too early death. I quote:

"It was my good fortune, when green from the Schools, to come under the inspiring influence of Dr. R. A. H. McKeen during my first practice (twelve years) at the colleries in Cape Breton. He was then a veteran colliery physician and surgeon; easily the Chief, and within and without the limits of his extensive practice at Glace Bay, was held in highest professional and personal esteem.

"Throughout his career the general practitioner, he comes in my mind, as I write, in the more strongly focused light of the Surgeon. He learned Surgery in what the highly specialized teaching of our times call the hard may. But for McKeen it was not hard. A benign and discerning nature gave him the lift: and a big and industrial community craving the relief that the surgical art alone could supply gave him the field to fit his talents and his great enthusiasm to improve the way of his calling. For some years he stood practically alone in anything approaching major surgery. No hospital near, and improvised operating rooms, often in poorly equipped homes, were the vogue for most emergencies. His success and zeal in his surgical work not only witnessed and tempered his experiences and skill, but aroused the consciousness of the public to the necessity for a well organized hospital, which in due course was erected and furnished with the best equipment of the time."

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*Reprinted from Golden Gleanings, Commemorating Fiftieth Anniversary of St. Joseph's Hospital.

This was St. Joseph's hospital, now celebrating its Golden Jubilee.

What St. Joseph's Hospital has done for this large and important part of our Province is now history that lives in deeds as well as years, and in a service that reaches far into the welfare of our social and economic structures, and touches the very heart of humanity itself. It has grown in stature, and all the material assets that ever advancing science demands, to give our treatments and techniques their best effect.

Behind all this lies the basic character of the hospital, and herein move the men and women who directed, and are directing its activities through the years. They are the laborers in God's vineyard whatever their creed or color, for none better than a well conducted hospital in its character reflects the great Christian virtues of Faith, Hope and Charity.

My particular assignment, however, is to tell something about the early Medical Staff of the Hospital. They were the doctors of the collieries in and about Glace Bay. I confess to one rather important qualification for the task. I am sure the good Sister Aneas, when she asked me to write, was guided by this particular fitness of things. For I alone of the doctors who formed the Attending Medical Staff, when the Hospital opened in 1902, am alive. The rest, my old confreres of other years, have one by one laid down their burden by the side of the half century trail, and bowing to that inevitable decree, which defies medical science, passed on to that "mysterious realm, from whose bourne no traveller returns." I can see them all as they come before memory's footlights on the great day of the Hospital's opening and dedication: McKeen, with a slight impediment in his stride from an accident in early youth, steps across the stage, stopping a moment by his assistant, Dr. E. O. MacDonald, to remind him that Donald Rory's wife was now having heavy labor pains, and that he should not tarry too long. Little silver threads are beginning to show on his large well-moulded head, giving a softening touch to the strong eager face that this day beams with satisfaction at the things already accomplished, and the greater ones that lay ahead. He sees Miss Cameron and they chat together, perhaps of things past and gone in their native village of Mabou; or, more likely, both were examining ways and techniques, she as Superintendent of the new hospital,and he, the head of the Attending Medical Staff. Both were schooled in the part they are to play, and both with character and strong sense of duty drawn from the earlier environment and Christian ethics of two of the leading Scottish families in Cape Breton.

I am a believer in the essential character of beginnings in any enterprise; and a hospital is first in my reckoning. It has many facets that touch very closely the aid of the sick and the stricken that seek its beneficent service. To restore them to normal health, to send them back to their homes and loved ones to continue the normal activities of life and happiness are gifts the garnished wealth of the world could not accomplish through other channels. Sound principles, formulae and discipline were established in the first years of St. Joseph's Hospital, and under able supervision, became the routine practice of the institution. Into it all was breathed the essential spirit of high character which, on the evidence of succeeding managements and Staffs, it still retains in undiminished honour.

Were it given the spirits of departed ones of the Medical Staff to revisit

the glimpses of former haunts, they would find the old buildings had added to their numbers, with external trappings to match; and to their delight, the spirit and service that guided and made it great in its beginnings were being increasingly reflected through the progress of the years. And so we leave our reflections for the moment and return to the personnel of the first Medical and Surgical Staff. Such reflections crowd in upon the mind as one tries to peer through the haze of a half century's changes and events in order to weave them into our theme.

The large green in front of the new hospital is now covered with citizens of Glace Bay and surrounding countryside. The full Medical Staff is there, except Dr. E. O. MacDonald who has just answered the call of a woman in childbirth; such calls knew no day or night, no business or social functions, and never fell on deaf ears among the colliery doctors. A large part of their practice was Obstetrics, and the practitioners with several years experience at the Mines became well schooled in the obstetric art.

Of these, the most outstanding in this, and many more of the segments that cover the whole range of general practice, was Dr. William MacKay. I can see him, as I write, moving among the crowd at the opening, shaking hands with old and young friends, telling yarns of other and earlier years at the Mines; and, in his characteristic zest of humour, detailing the oddities and eccentricities of some notable character who lived and wrought in those more primal times. Next to Dr. Marcus Dodd, Dr. MacKay was the eldest of the first Medical Staff.

During the years I practised at the collieries, he devoted all his time and energy to his big general practice at Reserve Mines. But in earlier years he had shared his service with other departments of activity. Provincial politics attracted him, and successes at the polls placed him for a period as leader of the opposition party in the Nova Scotia Legislature. He was a good speaker, big-hearted with a lump of Scotch humor that could leven the paste of any subject under discussion. Even on the edge of tragedy he could touch the event with little passes of humour that almost made one forget the darker side. I trust I may be pardoned for one illustration.

One evening at the Hospital, when our Staff had completed its business, the talk turned to injuries and burns from lightning. The erratic character of thunder-bolts in general was being spun out into pretty fine threads when Dr. MacKay, chairman of the meeting, and silent up to that point, broke into speech. "I will tell you a real, and very near tragic, experience I had many years ago in a thunder storm. I could even show you a permanently weakened right arm and leg with scattered electric burn scars all over them as evidence of which might have been. It was the closest brush with death I ever had.

"I was attending a confinement case at the old Gardiner Mines. It was a hot afternoon in July. My patient's home was small, with one living-room which served the purpose of kitchen, pantry and a shake-down corner, should emergency sleeping quarters be required. The patient's room was off the living-room. The inevitable granny nurse of the neighborhood—one said to be handy in such cases—had arrived and was getting things tidied up for the event, which I told her would probably be over in an hour or two. The day was sultry and hot, and a wicked black cloud passing low over the house threw

its sombre shadow into the room. I was walking back and forth trying to pass the time and compete in patience with Dame Nature that, operating in its oldest and sublimest mission, rarely makes a mistake. Between the groans of the patient's pain from the other room came the cheering voice of the good old granny nurse. 'It will soon be over, dear, keep up your courage; trust in God, and bear down with the pains.' Other sounds were the rapidly approaching thunder storm, and as I stood in front of an old fire chimney looking at a newspaper picture of Sir John A. Macdonald, my memory records a splintering crash—the rest was blackness."

The rest of the doctor's story was the re-telling of the nurse's service, which undoubtedly saved his life. The bolt did not set the building afire. The nurse rushed to him, found him flat on his back and, as she thought, dead. He was not breathing. Help was impossible. What should she do? There flashed on her mind that once in her school days she saw rescuers drag a man from the water of the Bay, and though seemingly dead, was revived by rolling him on a barrel. Well, the barrel and the doctor's great weight ruled out such technique, but rolling was left, and there was the floor. So she started. From one wall to the opposite the rolling went on until at last, on the verge of exhaustion, she heard a gasp, then some quick, short respirations verging into normal breathing. Then she knew she had won, and returned to her case in the next room.

Later on, when the doctor recovered consciousness, he found the nurse sitting beside him holding the newborn infant in her arms, while its mother was quietly sleeping off the exhaustion of a long and tedious labour in the next room. Hospital care soon put the doctor on his feet again, though he bore through the years some physical evidences of his encounter with Jove's thunder-bolts. A latch key and some coins in his right trouser pocket were melted into a mass, and are on exhibit in a museum, I think he said in Ottawa.

The next member of the Staff present at the opening was Dr. Marcus Dodd. He was a trifle late in arriving, perhaps having walked the distance from his home in Bridgeport to the hospital. He was, I think, the oldest of the Staff. He had reached a semi-retiring age, confining himself mostly to office consultations and near-by calls. His interest in the new Hospital, while genuine, was necessarily academic for in the widely scattered areas that furnished his field of practice through his earlier and busiest years there was little time for "refresher courses" or hospital visiting in order to keep in touch with newer treatments and techniques. And like others in more primitive times and conditions he had to mould his physical and mental resources to do the best he could for the sick and stricken in his care. Some of it might strike like a radio soap program on the sensitive ear of the modern doctor or specialist; but, for all that, there was in the circumstances much of good judgment and an abundance of common sense.

Practising near him during my years at Dominion, I had many contacts with Dr. Dodd. He often called when needing help, and his hospital cases were usually in my care. I liked the old man. I must forbear in this writing the many stories he told me relating to his practice in years far back; some of the best of them had no relation to his practice. Dr. Dodd came of a family once prominent in the early politics and judicatory of Nova Scotia, one a con-

temporary of Joseph Howe. The heredity strain was evident in the doctor. Of the old school of medicine and medical ethics, he was ever the gentleman.

Next of the Staff Members in the order of seniority is Dr. Murdock D. Morrison, colliery doctor in the town of Dominion. He had been assistant to Dr. MacKay for a while before taking an independent practice. Both in ability and experience he was well equipped for the large general practice he faced. I came into the same field following the opening of the hospital, and during my twelve years here our practice included Dominion, Bridgeport, Gardiner Mines district and Lingan. They were busy years. But, on the whole, they were happy years. We had the mental and physical energy of our years to face the countless variety of the ills and the accidents and misfortunes a coal-mining community seems to have in full measure. Besides, specialists were notable only for their entire absence from the whole area. The specialty of Psychiatry was in an embryonic state, confined to the art and understanding of the practitioner himself. There are many who think it should have stayed there.

Dr. Morrison was born at St. Anne's, C. B., afterwards, for no reason ever discoverable, named Englishtown. Sherlock Holmes and Dr. Watson might find a few Anglo-Saxon by following other clues than their tongue, for they would all be speaking Gaelic. This, however, is perhaps an exaggeration. It was a thriving village, had a good school, and there Murdock Morrison got his early education. He grew up in the tradition of the famous Reverend Norman MacLeod who, in the pioneer years of the district, ruled with an iron will, and hand to match, and whose name has passed down into the rugged history of Cape Breton.

Besides his professional activity, Dr. Morrison served his community well. Cultural and welfare organizations in general always found in him a friend and helper. The well remembered Dominion literary class was in part due to him, and some other interested ones in the town. It was a splendid success, achieved more than provincial recognition, and lingers in my memory as one of the shining lights in my years of service at the Mines. Dr. Morrison spent his later years in Halifax as Medical Officer of the Workmen's Compensation Board, and his tragic death in a car accident a few years ago brought sorrow to his many friends.

Dr. S. J. MacLennan was the last of the Staff personnel that established independent practices at the Mines, prior to the opening of the hospital. Dr. E. O. MacDonald was still with McKeen, and Dr. M. T. Sullivan was about starting at Dominion No. 2; Dr. Green was assisting MacKay, and preparing himself for his future field in Glace Bay.

'Dr. Sam", as we always called him, was not an easy character to write about This, despite the fact that our relations, both professionally and otherwise, were intimate and enduring. Perhaps his Highland caution kept at times some well-guarded chambers in his wellstocked brain, to avert misinterpretation. One morning I was doing a post operative dressing in the ward with Miss Allen, a clever pupil nurse assisting. She seemed a bit flustered about something, and I remarked, "a little bit off colour this morning, Miss Allen?" She answered: "I just had a bout with Dr. MacLennan, and he has the most perverted sense of humour of any man I ever met." Well, perhaps, a guarded brain chamber did leak in this instance, or, maybe the nurse was unduly critical.

None rejoiced more in the coming of the new hospital than Dr. Sam. "Now we can do something for ourselves as well as for our patients," he said, indicating, of course, the priceless opportunities we should have to develop increasing skill in the art and science of Medicine and Surgery. I recall an occasion. I found, following an autopsy, myself in lawful possession of the deceased's brain. ("Relatives" consent complied with.) The organ was carefully preserved, and supplied some anatomical research for Dr. Sam and myself during the winter. A small back office in my house was our dissection lab, and one evening a week our hours of study.

Dr. MacLennan's name appears on the Official Hospital Staff at the opening, as general practitioner, and aurist and oculist. He always harboured the idea of developing a specialty and giving up Colliery practice. The Hospital facilities enabled him to develop his techniques in Eye, Ear, Nose and Throat; his practice covering the whole service. Later on, a course in London in his specialty, then Halifax, where for the rest of his active life he was well and favourably known as a successful specialist.

It would take many pages of this manuscript to recall even a fraction of my memories of Dr. E. O. MacDonald and Dr. M. T. Sullivan. I am placing them together for convenience in writing; certainly not for any fusion of nature's physical stamp upon them, nor indeed on their respective characteristics and mannerisms. In other words, they were very different types. Both able, hard workers, and serving the largest colliery practice in Glace Bay. Though a part of the Town, it was officially named New Aberdeen, despite, it was alleged, Dr. Sullivan's protest that it should have been given an Irish name, since all the important people there were Irish.

In social and business life Tom Sullivan was a man of many moods, and he could fit them to meet either calm or storm. He had a ready wit and repartee, which he would turn to his advantage when an argument became too tense to be comfortable. McKeen said to him one day when he was haranguing pretty bitterly about something or other, "if you don't stop that, Sullivan, you'll go to hell." "What of it?" he answered, "I'll have good company there; a lot of my own relations and friends are Protestants." Needless to say, laughter and change of atmosphere followed. He saw out his whole professional life at the Mines, and attained a high standing as a Surgeon and general practitioner.

I could write much on my own early contacts with Dr. MacDonald. Just a little must suffice. We were often in the operating room together, taking our turn as operator, assistant or anaesthetist, as circumstances required; Sullivan, too, was often with us. We were all three, in a sense, juniors of the Staff, although Dr. E. O. had considerable experience, and a good consultant or assistant. Both of us were ambitious to advance in surgery particularly, and bore similar attitude of thought and observation to this end. I have many and grateful memories of him in those days.

Both physically and in all the attitudes of mind and personal behaviour, he was the living antithesis of Dr. Sullivan. He was tall, lean and straight all the way down. He had a quiet sense of humor, and a smile which mellowed what otherwise might seem a rather dour countenance. Like many of us, he reached the medical profession by a trail blazed and smoothed by hard work and

a strong will. He pioneered in education on the Western prairies teaching school, and in the best tradition of the Scot, protecting the earned profits for future use in the Medical School. One need not comment on such as a character builder, and the leven that raises and stimulates ambition to bigger and better things. His able service as a doctor here is ample evidence. In his later years of general practice, he qualified as an Aurist and Oculist, and carried on both until health and overwork called a final halt.

I think I have come to the end of my swallow-flight glimpses of the first Medical Staff. I know but too well how inadequate they are. Of Dr. Green, my recollection is that he was assistant to Dr. MacKay at the time of the opening and gave promise of becoming the able physician and surgeon the years following proved him to be. I had but a slight personal acquaintance with Dr. Haszard. I don't recall ever seeing him at the hospital.

Concerning Dr. John Stewart, who honored the Staff by becoming Surgical Consultant to the hospital, I am submitting a pamphlet for the hospital record containing three articles, written following his death at the request of the Canadian Medical Association. One of them is mine; and I offer it now as my tribute to this great Nova Scotian.

Writing of those we admire and recall does not imply an obligation to write about oneself. I must say this, however, for it fills my thoughts, that whatever success I may have attained, in a very long professional life, grew, in large measure, from the groundwork my practice here, and the inestimable experience, and inspiration St. Joseph's Hospital offered, in the field of Surgery. Many times, as a professor of Surgery at Dalhousie, have I related for the benefit of my class, the clinical history of interesting cases I had seen and treated at St. Joseph's.

To the present Medical and Surgical Staff of the hospital I extend congratulations. They are keeping up the best traditions of the past, surpassing them, in all likelihood; for our Science and Art have grown with the years, and the newer treatments and techniques, unknown in an earlier decade, are now within reach for their well-trained judgment and skilful hands.

My special tribute of praise to the Sisters of St. Martha. They took over the hospital's management following Miss Cameron's retirement, and with this, the high standards already established there. The services rendered our Province by this great Order, both in the field of hospitals and public health, are quite beyond praise. "By their fruits ye shall know them." No one that sweated out a period in public health in Nova Scotia can ever forget Mother Ignatius. My own memory is still good.

A parting memory of the members of the first Medical Staff, that have gone on before, may not be expressed in the old pagan formula of farewell Ave frater, adque vale. Rather would I say to each of my former confreres: Nunc vale, care frater et amice, adque in aternum ave.

Poliomyelitis Vaccination Programme in Nova Scotia, 1956

Issued by the Department of Public Health

THE Department of Public Health expects to obtain a further limited supply of poliomyelitis vaccine for immunization purposes this year. A decision has been made to offer this vaccine for the immunization of the group of children in which the incidence of poliomyelitis is greatest.

An advisory group to the Department, including representatives of The Medical Society of Nova Scotia, discussed all aspects of the immunization programme. This is a summary of the decisions reached by that group. A mimeographed release has already gone to physicians in the province giving them this information. It was felt that as many physicians as possible should have some knowledge of what was proposed before any public announcement was made.

It is expected that 280,521 c.c. of vaccine will be available for use in Nova Scotia, the first shipment arriving early in April. To the best of our knowledge at this time, this is all that will be available to us this year. Of this amount 17,431 c.c. will be used to provide booster doses for those who received vaccine in 1954 and 1955. The remainder of the vaccine will provide three doses of vaccine for approximately 87,696 individuals. This figure is very close to the number of children in school from Primary to Grade VI, some of whom have previously received the vaccine. It is this group of children to whom the vaccine will be offered.

It was felt that vaccine should be also offered to pregnant women, if possible. It is understood that children in institutions will be immunized. As soon as vaccine is available, it will be made available to children in the pre-school age group.

It was decided that two doses of vaccine, 1.0 c.c. each, should be given at an interval of one month. A third dose is to be given about seven months after the second dose.

Because of the desire to complete the first two doses as soon as possible before the polio season and the large numbers of children involved, it was felt that the only way to carry out this programme would be to organize group clinics at schools and to complete the administration of the first two doses of vaccine by June 15. Community groups will be asked to assist and to arrange with physicians to do the immunizations. Vaccine, supplies, and the services of the Public Health Nurses will be provided free by the Department of Public Health.

A circular letter has been prepared for distribution to parents whose children come in the group chosen for immunization. This letter describes the immunization programme and suggests to the parents that the physician doing the immunization be paid a reduced fee. They are also told that all eligible children attending an immunization clinic will be treated whether or not the parents can pay.

A request signed by parents or guardian must be presented before immunization will be carried out on a child.

As soon as sufficient vaccine is available, it will be released to the medical

profession for use with their private patients. The vaccine is supplied in 6.0 c.c. glass ampoules and it is felt that too much wastage might result if the vaccine were released to the profession at this time considering its limited supply.

A decision was made by the group that Public Health Nurses should be allowed to do immunizations in isolated areas of the province under the supervision of the Divisional Medical Health Officer and after consultation and agreement with the medical practitioners serving the area concerned.

An Evaluation of the Canadian Poliomyelitis Vaccination Program, 1955, has been made by Dr. E. H. Lossing, Chief, Epidemiology Division, Department of National Health and Welfare. The following are the conclusions reached in this evaluation:

CONCLUSIONS

1. It is shown that the incidence of poliomyelitis in Canada in 1955 was exceptionally low. The reported incidence rates of poliomyelitis all forms, in 1955 was the lowest in ten years, while the incidence of paralytic poliomyelitis in 1955 was lower than any year since 1950. In only three provinces did the 1955 incidence of paralytic poliomyelitis approach the 5 year average.
2. In all provinces where paralytic cases occurred in the vaccinated or unvaccinated groups, the attack rate in the unvaccinated exceeded the attack rate in vaccinated children of comparable ages during the period of observation.
3. In provinces where the 1955 incidence of paralytic poliomyelitis was low in relation to the 5 year average, these differences, although observed, were not statistically significant.
4. However, in the three provinces where the 1955 incidence of paralytic poliomyelitis more nearly approached the 5 year average, these observed differences in the vaccinated and unvaccinated groups have statistical significance, assuming that the vaccinated and unvaccinated populations were similar in other respects.
5. It is concluded, therefore, that a protective effect from the vaccine might be inferred in areas where the 1955 incidence was low, and was demonstrated where the 1955 incidence more nearly approached the 5 year average.
6. Poliomyelitis vaccine as used in Canada in 1955 was safe.

J. S. ROBERTSON, M.D., D.P.H.,
Deputy Minister.

JOINT MEETING OF THE THIRD CANADIAN MEDICAL CARE CONFERENCE AND THE MEDICAL CARE SECTION OF THE CANADIAN PUBLIC HEALTH ASSOCIATION

On May 31st and June 1st, at the Admiral Beatty Hotel, Saint John, N.B., there is to be held the Third Canadian Medical Conference, in conjunction with the Medical Care Section of the Canadian Public Health Association.

The Canadian Medical Conference, which has had successful meetings at Quebec and Edmonton, has a Central Steering Committee with representation from the Canadian Medical Association, the Canadian Hospital Association, Trans-Canada Medical Plan etc.

The Local Program Committee, for the present meeting, has representation from all four Atlantic Provinces. The members from Nova Scotia are: Rev. Mother Ignatius, Mrs. Gladys Porter, Dr. D. M. MacRae, Dr. C. B. Stewart, Dr. N. H. Gosse and Dr. G. G. Simms.

The program, which is set forth below, is both timely and interesting; it should be of particular value to those interested in the fields of medical economics and Health Insurance.

Those attending the meetings are advised to make their own reservations at the Admiral Beatty, Royal etc.

JOINT MEETING OF THE CANADIAN MEDICAL CARE CONFERENCE AND THE MEDICAL CARE SECTION, C.P.H.A.

ADMIRAL BEATTY HOTEL, SAINT JOHN, N. B.
MAY 31-JUNE 1, 1956

MEDICAL CARE SECTION, C.P.H.A.
MAY 31, 1956

Chairman C. B. Stewart, Dean of Medicine, Dalhousie University, Halifax.

2:30 p.m. ***Some Patterns of Medical Care from the Canadian Sickness Survey.**
R. Kohn, Ph. D., Chief Public Health Statistics Section
Health and Welfare Division, Dominion Bureau of Statistics, Ottawa.

3:15 p.m. Panel Discussion, **Proposed Federal—Provincial Hospital and Diagnostic Services Program.**
Mr. J. Sparks, Research Division, Dept. National Health and Welfare. Ottawa.
Dr. M. I. Roemer, Director, Medical & Hospital Services, Regina. Sask.
Dr. J. S. Robertson, Deputy Minister of Health, Halifax, Nova Scotia.

4:30 p.m. Business Meeting—Medical Care Section, C. P. H. A.

*In co-operation with the Vital Statistics Section.

CANADIAN MEDICAL CARE CONFERENCE.
JUNE 1, 1956

Chairman—Dr. J. A. MacMillan, Executive Medical Director, Maritime Hospital Service Association.

9:15 a.m. **The Place of Medical Co-operatives in a Complete Health Plan.**
Mr. Alex Laidlaw, Assoc. Director, Extension Department
St. Francis Xavier University, Antigonish, N. S.

10:00 a.m.
(1) **A Board Chairman Examines Principles of Responsible Trusteeship of a Typical Blue Cross—Blue Shield Plan**
Dr. J. A. MacDougall, Board Chairman, Maritime Hospital Service Association, Saint John, N. B.

(2) **His Plan Administrator Examines Principles of Responsible Mana e-ment.**
Miss Ruth C. Wilson, Executive Director, Maritime Hospital Service Association, Moncton, N. B.

11:00 a.m. **Prepaid Medical and Hospital Care by the Check-off System in Cape Breton.**
Dr. H. J. Devereux, Chairman, Medical Economics Committee, Medical Society of Nova Scotia, Sydney, N. S.

11:45 a.m. **Recent Developments in Group Health Insurance.**
Mr. Carman Naylor, Associate Group Actuary, London Life Insurance Co. London, Ontario.
Chairman—Dr. G. H. Hatcher, D.P.H., Assistant Professor, Dept. of Public Health Administration, University of Toronto.

2:30 p.m. **Merits and Demerits of a Plan for Prepayment of Medical Care Under a Physician Sponsored Agency.**
Dr. J. F. L. Woodbury, Chairman, Committee Studying relationship between Maritime Medical Care and The Medical Society of Nova Scotia, Halifax, N. S.

3:15 p.m. **Medical Services in the Nova Scotia Dept. of Welfare.**
Mr. F. R. MacKinnon, Director of Child Welfare and Mothers' Allowances, Nova Scotia Dept. of Welfare, Halifax, N. S.

4:00 p.m. Business Meeting.

Week in Surgery—April 23rd-27th, 1956

In presenting this fifth annual short course in Surgery for general practitioners, the Post-Graduate Committee and the Department of Surgery of the Faculty of Medicine of Dalhousie University are indeed pleased to welcome Dr. Martin M. Hoffman, as guest teacher.

COURSE PROGRAM.

Monday, April 23rd, 1956.

9.00-10.00 "Intestinal Obstruction"—Dr. W. A. Curry.
10.00-10.50 "Management of the Jaundiced Patient"—Dr. M. M. Hoffman.
11.00-12.00 Ward Walk—Dr. W. K. House.
12.00- 1.00 "Medical Aspects of Poor-Risk Surgical Patient"—Dr. M. M. Hoffman.
2.30- 3.15 "Use of Hydrocortone in Office Practice"—Dr. J. H. Charman.
3.15- 4.00 "Treatment of Fractures of Mandible and Maxilla"—Dr. D. E. MacLachlan.
4.00- 5.30 Symposium—"The Bleeding Woman"—
Moderator: Dr. H. B. Atlee.
Gynaecological Staff.

Tuesday, April 24th, 1956.

9.00-10.00	"The Diagnosis of Endocrine Tumours"—Dr. M. M. Hoffman.
10.00-10.50	"Medical and Surgical Aspects of Thyroid Diseases"—Dr. D. L. Roy Dr. A. L. Murphy.
11.00-12.00	Ward Walk—Dr. E. P. Nonamaker.
12.00- 1.00	"Surgery in the Diabetic Patient"—Dr. M. M. Hoffman.
2.30- 4.30	Symposium–"Burns–Shock and Electrolyte Balance"— Moderator: Dr. J. H. Charman. Dr. M. M. Hoffman. Dr. H. C. Read,
4.40- 5.30	"Minor Surgical Procedures"— Dr. G. J. LeBrun.

Wednesday, April 25th, 1956.

9.00-10.00	"Lesions of the Stomach"—Dr. V. O. Mader.
10.00-10.50	"Lesions of Rectum"—Dr. C. E. Kinley.
11.00-12.00	Ward Walk—Dr. H. L. Stewart.
12.00- 1.00	Tumour Clinic—Head and Neck—Dr. A. L. Murphy, Dr. H. D. O'Brien, Dr. G. W. Bethune.
2.30- 3.30	Ward Walk— Dr. N. H. Gosse.
3.30- 4.30	"Rehabilitation of Fractures"—Dr. G. J. H. Colwell.
4.30- 5.30	"Hernial Repair"—Dr. J. V. Graham.

Thursday, April 26th, 1956. (Children's Hospital)

Chairman: Dr. N. B. Coward.

9.00-10.50	Round Table—"Management of Common Fractures"—Dr. W. A. Curry, Dr. R. L. Smith, Dr. B. F. Miller.
11.00-12.00	"Appendicitis in Children"—Dr. J. W. Merritt.
12.00- 1.00	"Management of Rectal Bleeding in Children"—Dr. E. F. Ross.
2.30- 4.30	Department of Urology: "Undescended Testicle" —Dr. C. L. Gosse. "Problem of Non Specific Urethritis and Prostatitis"—Dr. G. Mack. "Haematuria"—
4.30- 5.30	"Fractures of Ankle Joint"—Dr. G. W. Bethune.

Friday, April 27th, 1956. (Camp Hill Hospital).

9.00-10.00	"Management of Occlusive Vascular Disease"—Dr. J. A. Noble.
11.00-10.50	Clinic on Back Pain—Dr. J. K. B. Purves.
11.00-12.00	Ward Walk—Surgical Staff.
12.00- 1.00	"Management of Compound Fractures"—Dr. H. D. O'Brien.
2.30- 3.30	"The Painful Shoulder—Dr. B. K. Coady.
3.30- 5.30	Open Discussion—Question and Answer Period: Dr. R. C. Dickson. Dr. H. B. Atlee. Dr. C. C. Stoddard. Dr. E. F. Ross.

* * * * *

Please direct your enquiries or applications to the Executive Officer Post-Graduate Committee, Victoria General Hospital, Halifax, N. S.

Registration fee is $25.00, payable on arrival in Halifax.

Thirty-five hours formal study credit will be allowed by the College of General Practice for attendance at all sessions of this course.

Abstracts

Clinical Aspects of Atypical Coronary Disease*

MORE cases of coronary arterial disease are being recognized to-day than formerly. In Great Britain there has been an increase in the Mortality from coronary disease in the post-war years, but the increase is less rapid than in the pre-war years. This increased mortality has occurred in spite of improved methods of treatment by anticoagulants, etc. Early and accurate diagnosis is therefore of fundamental importance in order that the treatment can be started as soon as possible.

Atypical angina pectoris and some of the clinical aspects of cardiac infarction are dealt with in the article. Some of the unusual forms of angina are as follows: (1) the reversed type where pain begins in the left hand, wrist or arm, or the left side of the neck, and radiates up into the chest, and is associated with the usual feeling of constriction in the chest; (2) the sensation of a band round the wrists or arms of the patient; (3) complaint of pain in the gums or jaws; (4) patients whose main concern in the choking or strangling sensation in the throat; (5) pain or "dyspepsia" after meals; (6) pain radiating from the chest into a phantom hand.

A diagnosis can be made in the atypical case of angina by a scrupulously taken history. The symptom (pain, discomfort, or constriction) is related to exercise and to a definite degree of exercise, and also to emotion. It is, in addition, influenced by heavy meals and a cold wind, each of which limits his capacity for exertion. Finally, his symptoms are almost always associated with a central chest pain, accompanied by a constriction in the chest, but this may be overshadowed by the patient's concentration on a symptom in another situation for which he presents himself.

Two aspects only of the problem of diagnosis of myocardial infarction are dealt with here. Firstly, are there any warnings of an attack of cardiac infarction, and, if, so, what are they? The second aspect concerns the unusual manifestations of cardiac infarction; particularly the patient complaining of abdominal pain, and also the patient with the so-called silent or painless infarct.

The two clinical pictures of cardiac infarction which are of greatest interest and most apt to lead to pitfalls in diagnosis are those presenting as an acute abdominal emergency and those cases in which pain is not a prominent symptom in the patient's history—that is the so-called silent or painless infarct.

A case of coronary thrombosis presenting as an acute abdominal emergency calls for consultation and close co-operation between surgeon and physician because this condition may simulate a perforated duodenal ulcer or gall stones. Help towards a correct diagnosis of myocardial infarction may be obtained by considering the age and sex of the patient, and the presence of any predisposing factor, such as hypertension, angina, etc. Conversely, a history of peptic ulceration or a long standing flatulence would point towards an abdominal cause for the pain. An immedicate ECG will give diagnostic evidence of infarction in a large number of cases. A silent or painless myocardial infarct is exceptional.

Some clinical conditions which should arouse suspicions of myocardial infarctions are (1) the onset of congestive heart failure; (2) acute pulmonary oedema and left ventricular failure: (3) unexplained irregularities of rhythm; (4) other signs of a failing heart, such as a gallop rhythm, pulsus alternans, and Cheyne-Stoke's respiration. These four groups are examples of the type of case in which careful and full investigation may reveal that myocardial infarction is the underlying cause.

Harris, K., British Medical Journal, No. 4944: 874-876, October 8, 1955.

Age and Sex Factors in Coronary Artery Disease*

Age and sex seem to have more to do with the aetiology and prognosis of coronary artery disease than has commonly been realized. These two factors are given particular attention in this analysis of the incidence and mortality of coronary artery disease in a large series of cases. The results are extremely interesting and in some respects surprising.

Included in the incidence study were 865 subjects who had undergone an "acute coronary episode." When the age factor was excluded, the proportion of males to females was found to be four to one. However, the ratio was different in different age groups. The incidence of coronary attacks in younger males was much greater: there were several "coronaries" in men aged 28 to 43, but the earliest age at which an attack occured in a woman was 43. After 40, the male incidence rose sharply reaching a peak between 50 and 59 and then falling almost as sharply as it had risen. In women, the incidence rose slowly but steadily from 40 to 70. Thus, when age is taken into consideration, the male:female ratio was 7: one before age 50; 10: one between 50 and 59; 4: one between 60 and 69; and less than 2: one from age 70 on. These incidence differences suggest that different aetiological factors are operative in the two sexes. While the almost straight-line progression of the incidence in females would seem to reflect the process of aging itself, the steep rise and subsequent fall in males indicates the presence of some other factor."Occupational stress" does not seem to be the answer, since the incidence in males shows a marked fall in just those five years which usually precede retirement, when the cumulative strain of the working life should be greatest. Oliver's hypothesis of an "inhibitory factor" operative in females during the sexually active period might explain why the incidence should rise in females after 60, but it throws no light on why it should fall after 60 in males.

Sex differences were also apparent in the ratio of attacks with infarction to those without. In half of the women, "coronary episodes" were associated with infarction, and its occurrence was not correlated with age. In men, this was also the case up to age 50. After this age, however, the likelihood of infarction was greatly increased; three-quarters of the "coronary episodes" in men after 50 resulted in infarction. The hypothesis is advanced that the ability or inability to develop an adequate collateral circulation is decisive in determining whether or not occlusion will lead to infarction. Up to the age of 50, both sexes seem to be equally capable of providing this collateral circulation—to the degree, that is, of forestalling infarction in about half of the in-

stances of coronary occlustion. This capacity is apparently retained by women throughout their whole lifetime, while it is considerably diminished in males after 50.

In assessing mortality and survival, 276 cases are considered. (These were patients treated before the adoption of anticoagulants. A later report will compare the results in this group with those in a later series receiving anticoagulants). Here, again, sex differences are interesting. The age factor proved to be much less important in females. There was no significant rise in immediate (6-week) mortality from coronary infarction with increasing age. In males, on the other hand, mortality after cardiac infarct was low before 50 (less than 5 per cent) but rose steadily thereafter, to 35 per cent at age 65. Oddly enough, however, the total mortality for females (all ages) was almost double that of males.

Survival records on 240 patients with cardiac infarct and 129 with cardiac ischemia showed life expectancy to be best in men aged 50 to 54 (average survival 6 years), worse in those aged 60 to 64. The prognosis is not so good in younger men: average survival was only five years for men aged 45 to 49, and only four years for men under 45. The number of females was small, but the evidence indicates that age of onset determines the prognosis: life expectancy was best in women under 50, diminishing steadily with increasing age.

Further attention to age and sex factors in coronary artery disease should illuminate some of the very suggestive but inexplicable findings emerging from this study.

Fitzgerald-Peel, A.A., Brit. Heart J. 17:319-326, July, 1955.

A Comparison of Cortisone and Aspirin in the Treatment of Early Cases of Rheumatoid Arthritis*

The therapeutic tests presented here were designed to answer the question of the possibility of maintaining the patient's well-being more efficiently by treatment with aspirin than by treatment with cortisone in the early and uncomplicated case of rheumatoid arthritis. The aim was to measure the therapeutic effects upon the rheumatoid process of long-term treatment initiated while that process was still uncomplicated, either by severe anatomical changes in the joints or by metabolic disturbances resulting from a prolonged and debilitating disease.

In total, 61 patients were admitted to the trial, 30 being allocated at random to cortisone and 30 to aspirin.

The results of the trial continue at the end of two years to show a similarity, between the two treatment groups, that is almost remarkable. In some respects the average values for the two groups have come even closer together than at the end of one year—either by slight improvement in the aspirin group, or a slight falling-off in the cortisone group. This applies to the range of wrist movement, the strength of grip,and the tests of dexterity. At the end of one year, it was shown that the haemoglobin level and blood sedimentation-rate had, on the average, responded rather more favourably to cortisone than to aspirin. This advantage of the cortisone group vanished during the second year. The mean—and frequency distribution of the sedimentation rates are

almost identical and the mean haemoglobin—levels no longer differ significantly.

Clinical assessments of the patients' conditions continue to show no difference between the two groups. With almost equal numbers at risk, four in each group were in remission. Six on cortisone and five on aspirin were "very active." Fourteen on cortisone and thirteen in aspirin were regarded as capable of doing their usual work and taking normal physical recreation. Nine on cortisone and seven on aspirin were still gravely incapacitated.

Medical Research Council, British Medical Journal, No. 4941: 695-699, September 17, 1955.

Emergency Treatment of Uncomplicated Myocardial Infarction*

The first necessity is the relief of pain. Morphine is the most potent analgesic. Levodromoran is a good replacement for morphine. Narcotics should not be used excessively, since sudden absorption of an accumulated dose may be fatal. Other pain-relieving procedures include papaverin, aminophylline, alcohol, stellate ganglion blocks, oxygen and anticoagulants.

By bringing a higher oxygen concentration to the injured myocardium, the amount of cardiac muscle necrosis can be decreased. Oxygen is a must in the first days of therapy unless emphysema complicates the situation.

Increased blood coagulability occurs in 74 per cent of myocardial-infarction patients. The advantages of anticoagulant therapy are: decreased mortality, decrease in venous thrombosis from the legs, fewer mural thrombi in the heart and reduced incidence of spread of the initial thrombosis. Anticoagulants should be used cautiously, especially with (1) prothrombin deficiency, (2) vitamin C deficiency, (3) renal insufficiency, (4) blood dyscrasias, (5) interruption of vascular continuity by surgery, (6) late pregnancy, (7) and subacute bacterial endocarditis. Control prothrombin times are needed daily. Heparin and discoumarin are given simultaneously till the latter exerts its effect. Protamine sulfate counteracts heparin action while Menadione or Mephyton are used in hypoprothrombinemic conditions or when the prothrombin time is greater than sixty seconds.

The fever occurring two to three days after myocardial infraction does not indicate infection. Thus, antibiotics are necessary only with pulmonary congestion. The fever put an additional strain on the body and may be reduced by the judicious use of salicylates.

Psychotherapy and rest are essential. Only the immedicate family may see the patient. Mineral oil nightly facilitates elimination. Complete bedrest is unnecessary and the heart load is decreased if the patient is allowed to sit in an armchair. Use of the commode is encouraged. Exercise of toes and ankles along with deep breathing will decrease venous stasis. Smoking is discouraged and alcohol given only in moderation. A mild sedative during the day followed by a hypnotic at night is useful. After five weeks, if no complications have occurred, if the temperature is normal and the sedimentation rate is declining, ambulation is permitted. At the end of the sixth week, the patient may go home where six more weeks of rest are prescribed. He can then return to work with a sensible showing of pace. Heavy labor and competitive sports are not permitted. The patient should feel that he is still a valuable and useful member of society.

Rosenberg, A. A., Journal of the Medical Society of New Jersey. 52: 421-425, August, 1955.
*From Medical Abstracts, November, 1955.
(These 4 abstracts are all from Medical Abstracts of November 1955.)

Risk of Surgery in Patients with Myocardial Infarction*

Along with the increasing average age of our population, there has been a concomitant increase in the incidence of degenerative heart disease. Many of these individuals are denied the benefits of surgery because the surgeon, the internist, the patient, or his relatives consider the risk too great. The authors have studied 70 patients who had definite evidence of myocardial infarction prior to surgery. These patients were subjected to a total of 111 operative procedures. There were four operative deaths, representing 5.7 per cent of the 70 patients, or 3.6 per cent of the 111 operations. Three of the deaths were due to acute coronary occlusion. There was a total of 20 complications following the 111 operations. Twelve of these were of the type that commonly accompany the procedures done. Eight, including the three fatal coronary occlusions, were cardiorespiratory complications. Successful management of the cardiac patient subjected to surgery requires good teamwork between the surgeon, the anaesthesiologist, and the internist. With careful management, the vast majority of these patients will tolerate surgery, and operative intervention should not be denied when indications are present.

Baker, H. W., Grosmer, J. T., and Wise, R. A., Archives of Surgery. 70: 739-747, May, 1955

Postoperative Vomiting: Incidence, Analysis and Therapeutic Measures in 3,000 Patients*

Postoperative vomiting has various causes: (1) reflex impulses arising in the pharynx, stomach, or other portions of the gastrointestinal tract may be excited by irritant drugs such as ether, blood in the stomach, or simple stomach dilation; (2) impulses received from the cerebral centres, rough handling of the patient in the immediate postoperative recovery period, vestibular stimulation following morphine administration or psychic stimulation; (3) chemical materials in the blood stream carried to the vomiting centre; (4) interference with the blood supply to the vomiting centre; (5) dehydration and electrolyte imbalance.

The incidence of postoperative vomiting has been determined in a series of 3,000 unselected patients. Two thousand cases served as controls, while 1,000 patients received parenteral marezine.

In the control group of 2,000, 545 patients vomited postoperatively (27.2 per cent). In the 1,000 marezine-treated patients, only 207 vomited (20.7 per cent). The incidence of vomiting in the marezine-treated patients was reduced by 23.9 per cent.

The use of ether and cyclopropane were associated with the highest incidence of vomiting, while pentothal sodium and regional techniques produced a lesser degree. Muscle-relaxant drugs did not appear to influence postoperative retching.

The open-drop technique of ether administration was associated with a high incidence of emesis. The partial-rebreathing and closed-systems produced the fewest reactors. Endotracheal intubation tended to reduce vomiting. Initiation of gastric suction during and after operation did not influence vomiting. Operations on the head and neck produced a higher frequency of emesis than intra-abdominal procedures.

Dent, S. J., Ramachandra, V., Stephen, C. R., Anaesthesiology. 16: 564-572, July, 1955.

Variable Patterns in Surgical Treatment of the Gallbladder*

There are many important variations, particularly of the ducts and arteries, that must be appreciated by the surgeon operating in the region of the gallbladder. The right and left hepatic ducts may not unite until they are joined by the cystic duct. The common bile duct may be unusually short as a result of the cystic duct joining the common hepatic duct quite far distally. An accessory hepatic duct can be easily overlooked during a cholecystectomy and lead to troublesome or often fatal postoperative complications resulting from leakage of bile. The cystic duct may be very short or even absent. If this variation is not recognized, the common hepatic duct may be included in the ligature in the belief that it is the cystic duct. It is well to remember that the cystic duct is the only tortuous hepatic duct. The common bile duct may sometimes empty into the stomach or occasionally be bifid with one outlet emptying into the pylorus and one into the duodenum.

There is a wide variation in the manner in which the common bile duct and pancreatic duct empty into the duodenum. The two ducts may joint proximal to the sphincter of Oddi; they may go through the duodenal musculature separately to empty into a single ampulla, and frequently they may have entirely separate duodenal orifices. The presence of inflammation may greatly increase the difficulty in accurately identifying these structures. The utmost care is required when working in the vicinity of Callot's triangle (formed by the common hepatic duct, and cystic duct, and the hepatic artery). This triangle is invariably present in spite of anatomical variations. The cystic artery is the single most important artery in this area. The author reproduces thirteen variations in origin of this artery according to Anson and Daseler. The need for making an adequate exposure and clearly visualizing Callot's triangle is stressed. The author recommends identifying and ligating the cystic artery before dividing the common duct. The numerous mishaps that can occur are described in detail along with precautions for their prevention and rectification. The indications and technique for choledochotomy and duodenal choledochotomy are presented.

Iason, A. H., Journal of the International College of Surgeons. 24: 233-248, August, 1955.

A Method for Control of Anorectal Haemorrhage*

The author has found that a No. 16 French urethral catheter with a 30 cc. balloon is an excellent means for controlling postoperative anorectal haemorrhage. The catheter is lubricated and inserted in the rectal ampulla for a distance of about four inches. The balloon is then inflated with either air or water. He uses an infant rectal syringe of one ounce capacity, this being easier to handle than the usual syringe. Downward traction is made on the catheter so as to exert pressure on the bleeding area. The catheter is then strapped to the buttock with adhesive tape. Counterpressure is applied by means of a perineal pad and an elastic T-binder. Gas or blood can readily escape through the catheter permitting the observation of the efficacy of the haemostatic device. Since the rectum is decompressed by means of the catheter, no bowel movements from reflex stimulation occur

Marshall, G. R., Journal of the International College of Surgeons 24: 97-99, July, 1955.
*From Medical Abstracts, October, 1955.

M.D. ARTISTS, PHOTOGRAPHERS INVITED TO TWELFTH PHYSICIANS' ART SALON

The Physicians' Art Salon Committee invites any Canadian physician or medical undergraduate to enter his work in the 1956 Salon to be held in the Chateau Frontenac, Quebec City, from June 11th to the 15th. This will mark the 12th year for this popular art and photographic feature of the annual C.M.A. Convention. It is sponsored by Frank W. Horner Limited, Montreal.

Conditions of Entry.

The Salon structure will remain the same as last year. Entries will be accepted in three sections.

(1) Fine Art.
(2) Monochrome Photography.
(3) Color Photography.

The Fine Art Section is further subdivided into traditional, contemporary (modern), and portrait categories. There is no restriction on media, oil, oil, tempera, gouache, water colour, charcoal, pencil, or dry brush are acceptable in each.

In Monochrome Photography, four entries may be submitted, but each exhibitor is limited to three entries in Fine Art, and Color Transparencies. And any exhibitor may enter up to the limit in one or more sections.

There is no charge. All costs, including transportation to and from Quebec City will be borne by Frank W. Horner Limited.

Judging of Awards

All acceptable entries will be displayed in the Salon and then judged for awards by a competent jury to be selected by the Art Salon Committee.

To Obtain Entry Forms

Any physician or medical undergraduate interested in submitting work may obtain an entry form with details by writing the sponsor at P.O. Box 959, Montreal. A short note or postcard will do. The entry form contains complete instructions on how to prepare and ship the entries.

Art Salon Calendar

A novel by-product of the Salon, the Physicians' Art Salon Calendar, will be prepared by Frank W. Horner Limited. The Calendar reproduces award winning work in full colour, and is distributed to all the physicians in Canada, with the compliments of the Company.

Obituary

Doctor Lewis Thomas, a veteran medical practitioner, passed away at the Victoria General Hospital on March 2nd, following a short illness. He was eighty-two years of age.

Doctor Thomas was born in Stellarton, N. S., and was a graduate of the Dalhousie Medical School, 1901. After completing post-graduate work in London and Glasgow, Great Britain, he returned to practise in the City of Halifax. For more than twenty years he taught practical surgery at the Dalhousie Medical School. He is survived by his sister, Catherine, Mrs. A. T. Spark of Halifax, and a nephew, Doctor Lewis H. Thomas of Regina.

Doctor William Alexander MacKay, age ninety, passed away in Thorburn, N. S. on March 17th. In recent years he had had to spend considerable time in hospital and had been in coma two days prior to his death.

Doctor MacKay was a native of New Glasgow. He first practised in Sherbrooke after graduating from Bell Hospital Medical College in 1895, and then moved to Country Harbour during the gold mining boom; however, most of his professional life was spent in Thorburn. During his early years at Thorburn he spent a great deal of time with horse and buggy visiting a widely scattered practice. His wife pre-deceased him in 1951, and since her death he had been living with his sister-in-law, Grace Stewart.