

# The Nova Scotia Medical Bulletin

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## Editorial Comment

Following the presentation of a Report from the Cancer Committee of The Medical Society of Nova Scotia to the Executive at the 1957 Annual Meeting of The Society the Executive of The Medical Society of Nova Scotia felt that a pamphlet outlining the aim and function, and day to day activities of the Tumour Clinic would be of great value to the medical profession at large in clarifying its role in the treatment and prevention of Cancer throughout the Province. Accordingly the statement which appears in this issue has been prepared by Doctor Norman Gosse, Director of the Nova Scotia Tumour Clinic, and is being distributed to all physicians practising in the Province.

This information is most opportune at the present time coming as it does when a series of Refresher Courses in Cancer, sponsored by the C.M.A. as a pilot project, are being held at various centres throughout the Province. If successful the C.M.A. plan to institute similar courses throughout Canada.

## Treatment of Compound Fractures

G. J. LeBrun, M.D., and F. G. Dolan, M.D.

ONE of the more difficult problems in the treatment of skeletal injuries is the management of compound fractures of an extremity. The surgeon's responsibility in the treatment of these fractures is the safest and earliest return to full function. He must necessarily be guided in the assessment of these fractures by the following factors:—

1. Degree of contamination.
2. Degree of comminution.
3. Condition of skin.
4. Number and type of associated injuries.
5. Blood and plasma loss.
6. Age and general status of patient.

It is dangerous to make hasty decisions in such cases and early operation has very few advantages and carries considerable risk of delayed union and chronic bone infection.

A compound fracture must, of necessity, be a contaminated wound from the moment the skin is broken. The size of the skin wound does not alter the basic concept that the wound is infected. Since the naked eye cannot determine when a wound is sterile we feel that the body's reaction, local and general, is the best indication of active infection. Signs of infection require time to develop; therefore, we should not introduce any foreign materials until all evidence of infection has subsided and healing of skin has occurred.

The general status of the patient is of vital importance in the plan of treatment. Any fracture of a major bone is associated with a 20% reduction in total blood volume. If the injury is compounded, there may be more extensive soft tissue damage with further loss of blood. As an indication of blood loss, it is to be remembered that any detectable increase in the diameter of the thigh, following a fracture of the femur, denotes the loss of at least 1000c.c. of blood into the area. Loss of volumes of blood in this magnitude may be readily tolerated by the previously healthy adult. However, these fractures commonly occur in elderly patients who may have a diminished total blood volume, and lesser degrees of blood loss may lead to shock in these people. Normal blood volume is the ideal state in the control of infection.

The process of repair, in the early stages following injury, involves formation of a haematoma. This is followed in the next few weeks by an invasion of the clot by fibroblasts. The open wound permits drainage of serum and infected material followed by gradual healing of the skin. We feel that this process of repair is not appreciably retarded by delaying open reduction for three weeks.

When such injuries are admitted to hospital the wounds are covered immediately with sterile dressings and supported with splints or sandbags. The general status of the patient is rapidly assessed. We attempt to assess the approximate amount of blood loss from the history, clinical appearance of the patient, local appearance of the limb, blood counts and blood pressure. The patient is cross-matched for blood, and given tetanus antitoxin.

If the skin wound is small, the adjacent skin is cleansed superficially and the leg immobilized by means of a posterior slab or full cast.

More extensive skin laceration permits thorough irrigation of the skin wound with saline or cetavalon, followed by partial loose approximation of the skin edges. The fracture is realigned by manipulation and a plaster cast applied. No attempt is made at extensive debridement of soft tissue or bone.

Extensive areas of skin loss demand more extensive planning. There must be thorough cleansing of the wound by irrigation and obviously contaminated and necrotic tissue must be excised. The fracture is reduced and the wound packed with aureomycin gauze. Immobilization is maintained by means of a posterior slab. The wound is re-examined in eight to ten days and is then prepared for grafting; a split thickness graft of eighteen to twenty-five thousandths of an inch is applied. Following complete healing of the graft the fracture is re-assessed and further treatment determined.

In the interval following the initial treatment the patient is kept in bed at rest with elevation of the extremity. Pain is relieved by mild sedation during the first forty-eight hours; after this period pain should only be a minor factor in management. Early active exercises are encouraged. The patient is given antibiotics, usually dicrysticin, for approximately ten days. During this period the patient should feel well, have a full diet and his temperature should return to and remain normal.

Many fractures so managed require no further operative treatment if alignment is good and immobilization adequate.

In fractures where the alignment is poor or stability questionable, operative repair is undertaken. *Operation should never be attempted in the presence of infection or incomplete healing of the skin.*

Operative repair of fractures demands strict adherence to the basic concepts of aseptic surgery, since open reductions, of themselves, create compound fractures. The incision and open reduction must be made and maintained in an absolutely sterile field. The skin is prepared by thorough cleansing with either soap or detergent and painting with a germicidal agent. Incision is made, if at all possible through normal undamaged skin. At no time should the skin be touched by the operative team and skin towels are invariably used. Ideally the 'no touch' technique should be employed. The fracture is reduced and the method of internal fixation is determined by the nature of the fracture.

## Exfoliative Cytology and Cancer Detection

C. D. Chipman, M.D.

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THE cytologic study of secretions and effusions from the body is a relatively new development in medicine. The principle depends on the fact that cells are always being shed or exfoliated into the natural secretions and into effusions. When a malignant tumour forms part of the wall of a serous cavity in which there is an effusion, or when it is present on a surface such as the uterine cervix, the number of cells cast off is increased. Microscopic examination of smears of the fluid or secretion may reveal the cells and the diagnosis of malignancy can be made from the study of their form.

The clinical use of this method began after the publication of a monograph, "Diagnosis of Uterine Cancer by the Vaginal Smear" by G. N. Papanicolaou and H. F. Traut in 1943. Since then the scope of the examination has been broadened to include sputum and fluids from the serous cavities. Recently the study of cells from the gastro-intestinal and urinary tracts has been introduced. In terms of accuracy and clinical use, studies of vaginal fluid and cervical smear cytology are the most important.

The value of this method of diagnosis depends on the detection of malignant lesions before they would be otherwise discovered, either clinically or by biopsy. It is also useful as a convenient method of screening a patient population. The greatest contribution of exfoliative cytology has been in the detection of carcinoma-in-situ of the uterine cervix and in the study of the natural history of this lesion. Here the malignant change is within the epithelium and precedes the invasive phase by months or even years. The cervix may be clinically normal and yet malignant cells are shed from the surface and may be found in smears. Cytology has no value in clinically far advanced malignancy in which biopsy studies would be indicated in making a pathologic diagnosis.

The ease and convenience of obtaining samples or repeated samples recommend cytologic study. The accuracy depends, however, on the material being collected under standard conditions and the results being interpreted strictly within the limitations of the method. The specimen must be obtained and handled with care. Exfoliated cells are delicate and withstand poorly the trauma of drying and smearing. The specimen must be labelled and sent to the laboratory as soon as possible if fresh, and adequately preserved if not. The cytologist must make a thorough study of the smear on its own merits, but should not be denied information from the clinical history.

The examination of isolated cells or groups of cells in a smear is not as accurate in diagnosing malignancy as the histological examination of a tissue. In smears the cells are separated from their neighbors and from the surrounding tissue. Smears do not show invasion, an important criterion in the diagnosis of malignancy. One advantage of cytology is that the smears show cells from a wide area whereas the histologic examination shows only those cells which are present in the tissue removed.

The diagnosis of malignancy from a smear is based on many factors, all of which may not be present. These include such direct changes in the cells as may occur in nuclear size and chromatin pattern. Certain indirect signs

such as the presence of blood and the grouping of the cells may suggest the diagnosis. There is thus no single specific sign which labels a cell as malignant. The diagnosis is based on the evaluation of the many changes seen and not on a single factor. In addition, any of these changes seen in malignant cells may be found in benign cells under certain conditions. The reporting of results in stages or grades emphasizes the fact that cytologic diagnosis is qualitative and not quantitative.

There are many pitfalls in cytologic diagnosis which include errors in collection of samples as well as errors in the examination of smears. The specimen may be taken from the wrong place. This can happen in cases of endometrial cancer in which a smear taken from the cervix may fail to show cells subsequently discovered in smears made from the aspiration of the endometrial cavity. In general taking smears from the cervix is an uncertain method of detecting cancer of the endometrium. In the cervix, smears made too far out on the ectocervix may miss cells being shed from a growth beginning at the squamo-columnar junction or within the endocervix. The shape of the Ayre spatula ensures collection from the endocervix. The presence of large amounts of blood or inflammatory exudate in a smear may conceal the exfoliated cells and make diagnosis impossible. In far advanced malignancy, not usually a problem in cytologic diagnosis, blood and necrotic debris often obscure the malignant cells. Frequently, infections such as those due to *Trichomonas vaginalis* lead to alterations in nucleus and nuclear chromatin which may simulate early malignant change in the exfoliated cells. Previous irradiation also causes changes in cell structure.

Exfoliate cytology as applied to cancer detection is of great value when used in conjunction with clinical investigation and adequate biopsy studies. The use of the method is limited by the techniques of collecting and preserving specimens and by the difficulties in interpreting the smears. The results of the examination should be taken into consideration with the clinical impression and a positive or suspicious report indicates the need for further investigation. The result of the cytologic examination should not be the basis of treatment of a patient. In all cases the result must be confirmed by biopsy.

Newer methods of examination are being developed which promise improvement in accuracy of diagnosis. Special stains which accentuate the changes in malignant cells will help to eliminate some of the errors of interpretation. Technical advances such as phase contrast microscopy are being applied to cytologic studies. However, until the recognition of malignant cells becomes more objective, diagnosis will continue to be subject to the limitations which have been outlined.

Papanicolaou, G. N. and Traut, H. F., *Diagnosis of Uterine Cancer by the Vaginal Smear*, New York: The Commonwealth Fund, 1943.

Ayre, J. E., *Cancer Cytology of the Uterus*, New York: Grune and Stratton, 1951.

Ayre, J. E. and Dakin, E., *Cervical Cytology Tests in Cancer Diagnosis*; Glycerin Technique for Mailing, *Canad. M. A. J.* 54:489, 1946.

von Bertalanffy, L., Masin, F., and Masin, M., *Use of Acridine Orange Fluorescence Technic in Exfoliative Cytology*, *Science*, 124:1024, 1956.

# The Role of The Physician in Our Present Medical, Sociological, Political and Economical Development

Prof. Hans Neuffer

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the German Aerztetag, Stuttgart-Degerloch

THE medical profession is a mixture of science, *art*, *craftsmanship*, *philanthropic work* and *business*. This forgotten interpretation of the medical profession merits renewal as it proves the complexity of medical activity. It is, therefore, not surprising that the public has a manifold picture of the physician. The photograph of the great surgical master over disease and death, surrounded by eager assistants and shining equipment, whose scalpel intrudes in the mysteries of life, appears again and again in the million editions of the illustrated press and is publicity attracting. But on the other hand we must not forget the picture of the practitioner—mostly unpublished—whose waiting-room is crowded, who stands at the disposal of his patients day and night in town and country, often under extremely difficult conditions. From him the insured members of social sickness insurance often claim too much and his fee has not kept pace with wage and price increases. But God help the physician if he once commits a professional error or makes a mistake due to human weakness. The press—and with it the entire public—tears him to pieces and tries to discredit the entire profession on account of this one event! All this is proof, that today *philanthropic work* and the *art* of the *physician* are not highly valued. *Science* and *craftsmanship* are more esteemed than all medical activity, which is considered basically a pure *business*.

Behind this veil of contradictory reflections the physician lives and works in his practice, in the hospitals of towns and rural districts. This he does as a member of a free profession which,—one of the oldest known to mankind with its ancient traditions—nevertheless has been subject to great change in this century of natural science, engineering and social security claims.

It would be foolish to deny the astonishing progress medicine owes to the cool objectivity of natural science and engineering. It would also be foolish to deny, that as a result of the abundance of scientific and technical findings, specialization of medical science became necessary. These led to the great achievements of medicine in the last decades.

It would, however, be a grave mistake not to consider this development critically and observe its disadvantages.

The material spirit of natural science, engineering and specialization threatens to influence the inexplicable *confidential human relationship* between *doctor and patient*. This induces the medical man to consider phenomena of disease objectively and to treat the patient in an impersonal way, without respecting him as unity of body, soul and spirit. This frequently heard hospital slang: "How is the gall-bladder in room 10?" instead of: "How is Mr. Smith on whom we operated yesterday for his gall-bladder condition progressing?", implies, that the respect for the personality of the patient is missing.

Such casual expressions though seemingly unimportant, suggest two basically different concepts of the nature of human illness.

We must remember that the *attitude of the patient* has also changed essentially since the beginning of the century. Modern man does not accept illness as his personal fate—part of his lot on this earth—but reacts against it as a tiresome disturbance. Consequently, he no longer views the doctor as the human helper in his illness-need, but regards him as a “health-engineer”, whose job it is to repair the disordered apparatus. The patient is no longer a “patient” but an impatient person not asking for help but demanding it. Thus he demands too much, not only from the physician—who has little freedom left within the system of social sickness insurance for personal consideration and responsibilities—but also from medicine itself. Such a patient expects the same perfection from medicine as from engineering and chemistry. These two have become the great idols of today, by which—as men believe—everything can be accomplished.

This change in the doctor-patient relationship is further enhanced *by specialization*. If the specialist is interested only in his particular branch, it becomes increasingly harder for him to consider the disease—behind the special symptoms—as an individual experience of his patient. The harmony between medical practice and scientific medicine has been gravely disturbed. In the evolution of modern medicine, however, certain factors are correcting this condition. The barbaric attitude of specialists—according to ORTEGA y GASSET—can only be overcome by the indispensable specialist remembering the other branches of his profession, and not losing sight of the medical condition as a whole in its relationship to the entire human being.

We are pleased to learn, that up to 50% of the attendance at the German postgraduate courses for practitioners consists of specialists. This proves that the latter recognize the general interrelationship and are also doing their best to revive it. But also the general practitioner should continuously work on his postgraduate education. Only will he be able to fulfill his task for suffering mankind by remaining scientifically up-to-date and by cultivating contacts with his colleagues who are specialists.

Another direct threat to the medical profession is the modern trend towards *increasing socialization of life into mammoth-collectivity*. Here we have two main factors concerning the nature of medical service and the position of the physician within society; namely the position of the doctor as member of a free profession and the nature of his cooperation within the system of social sickness insurance. Compared to the total population, the number in the free professions is relatively small. There is grave danger of their being carelessly crushed between the millstones of trade-union power and the financial power of the employers, because the tasks and services of the individual professions within modern society are neither economically nor socially properly appreciated. This became especially evident during the period of the economic reestablishment of the Germany of postwar years. Together with other free professions the medical profession is a member of that small group which did not participate in the German “economic miracle”, and which remained—from the economic point of view—far behind the other groups of the working population. Even if the average income of doctors has actually increased, one must remember that it cost dearly and compared to the increase for other professional groups developed more slowly.



At present there is probably no professional group in Germany which undertakes as much work and works as many hours as the practising doctor. To a considerable extent this overburdening and underpayment is related to the principle of material service and lump-sum payment of the social sickness insurance system. This system also introduces the danger of the anonymity of collectivity and the leadership principle of state officials between doctor and patient. The confidential relationship between two people—physician and patient—fundamental basis of all medical help and therapy—has been disturbed by a third party interfering with orders and prescriptions. This interference is not so much from the legal social sickness-insurance as such, but its present extension covering nearly the entire population and the present relations between insurance institutions and doctors, and between insurance institutions and the insured people which endanger the free medical profession to the disadvantage of the patient.

This does not mean that the blessings of social sickness insurances are to be denied. During the course of socio-historical development, it gave access to the doctor for large groups of the population. The social sickness-insurance system, however, developed its own automatism and now threatens to endanger its own results, if the reawakening of the self-responsibility of the insured, and the reestablishment of the undisturbed confidential relationship between doctor and patient cannot be achieved. This task is difficult, as it is both a health and a socio-political problem of first grade. Humanity is asking for ever increasing material protection, but the more the individual is relieved of the responsibility for the therapeutic costs of individual diseases by collective groups, the more the tendency of these groups to influence the actions and the behaviour of the individual patient and of his doctor increases. The patient should be cured as quickly and cheaply as possible. The patient, however, because he shifts from the self-responsibility of his health to the responsibility of a collectivity tries to get the greatest possible share out of the big pot for himself. The larger and the more anonymous these collectives become, the greater the danger of total misinterpretations of the basic principle of the cooperative system. Under these conditions health is no longer a personal affair, as it now constitutes a burden for others. This tragic conflict between the insured and his insurance group is actually fought today in the medical consulting room. The necessary compromise always must be made by the doctor and it reduces—as is clearly reflected in the pages of the press and public opinion—the social reputation and the public authority of the doctor. It undermines specifically that confidential relation—to the disadvantage of the patient—by which the doctor himself becomes medicine (Jores).

Furthermore, *the state* and its agencies continue to *invade medical spheres* which could be more efficiently handled by the practising doctor. Obviously the state must be responsible for public health. But a sharp difference should be made between tasks which can *only* be fulfilled by the state and tasks, which the state *may* handle, and the domains which will *never* be properly handled if the state interferes. The state's tendency to invade more and more the spheres of social and individual life by orders and regulations can become a special danger for the medical profession. State law underlines the predominance of personal responsibility over the regulations of each collectivity. As health is an important part of the entire human personality, everybody *a priori* is self-responsible for his own health. Health policy of the state should

not destroy or undermine this responsibility but should try to sponsor and develop it. Only then can the physician exercise his profession under proper conditions. One experience here is rather startling. Whilst the state irresistibly and steadily enters the most personal spheres of medical practice, health policy is treated in a stepmotherly fashion within the frame of general policy. Whenever the state should assist only by financial aid, it always considers other tasks as more important. This applies, for example, to the reforms of hospital affairs in Germany, which are long since overdue. It applies further to other spheres of preventive medicine, where the practising doctors should participate if they are to promote health, as well as cure disease.

The development of a health policy based upon personal responsibility, based on liberal ideals of legislation will only be promoted if the *doctors themselves participate actively* in the *formation of the state and society of the future* and also if they are not afraid of the strenuous political activity involved in countries and communities. Actually many doctors play a leading role in political life. Compared to the number of doctors within the entire population they represent a considerable percentage, but compared to the extent and number of political tasks needing medical judgment, the number is by far too small. This is because medicine as a vocation is rarely combined with political talent. The real doctor prefers the work in the quiet of his consulting room. The politician, however, stands most of the time in the limelight of publicity. But both have a certain social-mindedness in common, which is found especially in those physicians who participate in public life.

Therefore, and because the vocation of medicine is individual and idealistic, the state and society should not renounce these in political life. The present fight for self-preservation, fought by the medical profession as one group of the free professions against mass- and money-ideas, is not only fought for itself, but is also in the interest of a healthy social and political order. The crisis of the medical profession does not consist mainly of its economic and social difficulties, but of the dangers to the vocation of medicine.

Therefore, the fight for self-preservation should be combined with self-criticism. The ethical duties of the true profession of medicine must stand high and firm throughout the ages like a rock in the wild sea. Even if the role which the physician plays in the present medical, sociological, political and economic fields changes, the duty of permanent readiness to assist and render conscientious medical care service must not alter. The physician should remain a vital factor in the cultural life of man and he should strive to prevent the divine and human values from drowning in the hardships of our existence. The fundamental principles of the medical profession must remain *philanthropy and art*.

Reprinted from the World Medical Journal, July, 1958.

## Nova Scotia Tumour Clinic

When this clinic was opened a letter was sent to all doctors in the Province informing them as to the nature of the organization of this clinic and what it planned to do. As that was nearly five years ago, it should not be surprising that — as has been called to our attention by Dr. Carl Tupper, Chairman of the Nova Scotia Medical Society's Committee on Cancer — some doctors do not know how this clinic ticks.

In any event, the clinic is happy, not only to repeat the information given earlier, but to make further report in the light of its experience since the clinic began, on how this clinic works and thinks. No one here claims perfection in its operation, but all claim a very great advance in our approach to the cancer problem — an advance that is continuing and will continue — no matter who may come or go — so long as the spirit of the men who give service to this clinic remains and is fostered. The following is its story:

### History

For many years there had been a feeling among more thoughtful members of our profession that in this province, we were not giving the thought to the problems of malignant disease that we should. The whole approach to the subject was, to say the least, casual. The results were not what they might have been and to a great degree there was no system for checking them. There was no organization having to do with records by which a comparison of our results could be made with those of the many centres where good records were kept and where specialized efforts and skills were being applied to the subject.

In our provincial hospital, a gesture had been made in recognition of the importance of the work where periodically a half hour was given to the presentation of cancer cases before a regular clinical staff meeting. There was also adopted the cancer forms of the American College of Surgeons, but that was about the extent of its activities. It was probably because of those gestures, small though they were, that the American College of Surgeons, then the authority for the accreditation of hospitals "accredited" the Cancer Clinic in the V.G. Hospital. There is no doubt but that it was done as an act of encouragement, and not as the accolade of accomplishment, for though they left it so accredited for a number of years, at a later inspection the International Joint Commission for Accreditation, finding no development of the clinic along proper lines withdrew the accreditation. Until a still later inspection, we were without an approved tumour clinic in this province. Nor would we have obtained approval then if we had been doing partial operations in malignant cases, waiting on laboratory reports, and finishing necessary operative procedures days or weeks later.

Meanwhile, the demand to establish a proper clinic service in this province which had been voiced for some years increased. It was officially strongly backed by the Cancer Society in this province, which from its knowledge of other provinces, knew we were behind and of course the movement received great support when our accreditation was withdrawn. The Department of Health of this province then authorized the institution of a clinic

which eventually came to be known as the Nova Scotia Tumour Clinic. When this writer was asked to organize such a clinic, one condition was demanded, that he would be given opportunity and authority to visit such places on this continent as he would wish to visit with a view to determining from the experience of others what would best suit this province. Those terms were accepted and under that authority he visited twelve clinics in U.S.A. and Canada. (He had, only a few weeks earlier, visited New York clinics on his own. These are not included in the twelve).

Report was made on his return to the Department of Health and to the staff of the V.G. Hospital with Dr. Robertson, the Deputy Minister and Hon. Angus L. MacDonald, Premier of the province present. Recommendations were made and since they involved a great deal of additional free work on the part of the V.G. Hospital staff and a radical change in the type of practice in this hospital, time was given for consideration, and the present clinic system and practice were adopted at a later meeting.

It should be noted here that for some time prior to this, one hospital department had been operating a cancer clinic in its own specialty Gynaecology — and had well proved the value of specialization in cancer.

The matter of further specialization — of accepting the view that a man who sees 100 cases in a given time acquires more experience than a man who sees one — was the central theme in the new organization. The view was adopted that success would only accrue if the staff accepted not only an increased amount of voluntary service, but also a restriction of practice within the clinic and wards of the hospital and the acquiring of experience in one region only of the cancer field. This was a major change in the practice of most staff doctors. It was accepted, however, because it was patent that in the nature of things, they could not be expected to give as good service to patients coming to this centre if their interests were not concentrated in one field. The principle of specialization was established here in a manner and to a degree not hitherto done in this province, and in a manner done only in some of the best known clinics of the world.

Coincidentally with this there was begun a complete reorganization of the record system for cancer and a new system of doctor-reporting. With respect to the former, the record system and forms suggested by the National Cancer Institute of Canada have been adapted to our use so that insofar as they are used across Canada figures may be more readily compared. With respect to doctor-reporting, Clinic reports must be in the mail within 24 hours. Many are out in 6 hours. Delays are occasioned when tissue reports or X-ray reports are to be included.

#### **Division of Services or Clinics and Times of Clinics**

The following table indicates the special clinics and the days on which they are held:

Medicine (Leukaemias, Lymphomas, etc.)	— Mondays
Gynaecology	—
Miscellaneous (Surgery A)	— Tuesdays

E.E.N. & T.	—
Neurosurgery	— Wednesdays
Head and Neck (Surgery C)	—
Urology	—
Rectal and Recto-sigmoid (Surgery B)	— Thursdays
Breast	—
Gynaecology	—
Lung and Stomach (Surgery D)	— Fridays

Requests are sometimes made for patients to be seen on days other than those of the clinic concerned. This is not possible. Rarely a doctor sends a patient without a date having been given. This has, at times, been very inconvenient and costly to the patient.

#### (a) Clinic

There are no restrictions whatsoever for admission to the clinic except that admission is expected to be applied for by the patient's doctor, and a date and hour assigned.

All "public" tumour applications and all "private" ones for this clinic whether sent to the V.G. Hospital or directly to this clinic, are passed upon by this clinic. This is, in part, to see that with the help of the application form as filled up by the applying doctor, patients get to the proper clinic. It is also to expedite matters as far as possible and insofar as circumstances will admit to obtain priority for those cases that seem to more especially require it. The need for this will be the more readily appreciated when it is stated that "Head and Neck" days in this clinic may run to 35 or 40 patients in a morning of which 6 or 8 may be "new" and that "Breast" is running 22 - 24 cases of a morning with as many as 7 "new."

#### (b) Hospital

Recognizing the importance of "Cancer" in the overall hospital picture, the Victoria General Hospital has a healthy attitude in the matter of priority, but in a situation in which there are simply not nearly enough beds to go round and the pressure on bed space is so great the accommodation of 6 or more "new" cases and a varying number of "old" cases on any single day from a single clinic, repeated again next day from another clinic and that in an already full hospital is not without its problems. So far, somehow, they seem to find solutions without any significant or undue patient inconvenience except in the rarest instances.

### Cost to Patient and Allotment to Services

#### (a) Public - Clinic Services

When the clinic was set up it was understood that for the time being, admission would be, in all respects save one, by the same system as that which for years had been operating the General Outpatient Service of the hospital. Tumour patients are admitted by a nurse who fills up a general information card. This includes financial status and upon this they are coded.

Clinic charges then are by code, as follows: (Full O.P.D. charges are approximately 35% of regular.)

Code	New Patients	Return Patients	Radiation
A	\$1.00	\$ .60	Full O.P.D.
B	.75	.45	3/4 ,,
C	.50	.30	1/2 ,,
D	.25	.15	1/4 ,,
F	free	free	free

(it is obvious that these O.P.D. charges were applied for their psychological rather than for their economic value.)

(b) Public - Hospital Services

When a patient is admitted to hospital, he or she comes under the regular hospital system, the same rates applying to all ward cases, and who actually does the treatment is determined by the Chief of the particular service.

(c) Private - Clinic Services

All patients admitted to clinic receive exactly the same quality of treatment. No difference is made between poor and rich from the point of view of examination, clinical diagnosis and recommendation, or charges, except as shown above.

(d) Private - Hospital Services

1. Patients admitted directly to hospital on the private service of any doctor are — within the general rules of the hospital — entirely under that doctor's direction and the clinic has no responsibility except for the record which forms part of the Tumour Registry of the centre.

2. Patients who have been referred to the clinic as "private" patients and who therefore are admitted to the private section of the hospital, are generally admitted to the chief of the particular tumour service concerned, or to that of the person in charge of the clinic that day. That person assumes personal responsibility for the patient from that point though the patient, unless he or his family doctor decides otherwise, returns to the clinic for follow-up. The fact that a patient sent to this clinic is admitted under the care of a private doctor does not mean that the Clinic relinquishes its interest. It does not.

All allotments of private patients and any transfers from public ward to private accommodation are made on the principle that such patients have the right to request any doctor whom they are prepared to pay, and any doctor rendering such service has full right to submit a bill. (Some of the services make a fund of the fees collected from insurance cases done on the wards and utilize it for special equipment or as training grants. The Clinic maintains a small travel fund for clinic members to attend special cancer courses which was begun by the Director on that basis (from money collected by him on ward cases) and still is occasionally augmented from the same source. The Canadian Cancer Society makes a contribution to this travel grant.)

### Variation in ways of Admission of Patients

While generally patients are asked to come to clinic first, occasionally patients who would ordinarily be allotted to a clinic service, are instead admitted directly to a hospital bed. This is generally because of age or infirmity and the consequent inconvenience of going first to clinic. They are, however, assigned to the hospital service of which the clinic specialist is the chief. Occasionally others are admitted directly because it is apparent from the information given by the referring doctor, that certain investigative work will be necessary before a diagnosis can be made.

### Personnel

Each clinic carries its own group. Upwards of 30 doctors give voluntary service to this work. In addition, most groups have a Radiotherapist in association at the clinics — sometimes two. Senior men are in charge of clinics — occasionally an associate. The original concept of the clinic was consultation among the attending men and with the Radiotherapists. With the greatly increased experience and with the much larger clinics, a proportion of the work proceeds more or less according to a pattern and the time-consuming consultations are employed on the problem cases, which are individual. Finally major problems and matters of interest to all clinics are discussed at the "Tumour Conference." Doctors attend on their own clinic days and are not asked to see patients who come casually to clinic on other days. The importance of appointments for patients for their proper days cannot be overemphasized, if patient inconvenience is to be prevented.

### Treatment

Advice as to treatment is the duty of the clinical members of clinic staff. This is communicated to the patient. Generally it is accepted by the patient and carried out by the hospital staff. Sometimes it is not accepted for one reason or another.

The clinic assumes that the patient is submitted for such care as it is able to give, and proceeds on that basis. This has been questioned, in an occasional case, and it has raised the whole question as to who determines the treatment in such cases — clinic group or the doctor who refers the case.

It would seem that from the foregoing there should be little doubt as to who should determine the treatment; nevertheless, it has been argued that the doctor who referred the case should be the one to say what he wants done, and to expect that his ideas should obtain. Generally this is regarded as an impossible situation in which members of the clinic would, against the combined judgment of the clinic be expected to carry out treatment of which it did not approve. This has been presented to members of the clinic and the reaction has been — as one would expect — that they feel bound to give advice to any patient according to their best judgment; that the patient has the right to accept or reject such advice and that, in general, doctors would advance their own positions and the interests of the patient if the case were not prejudiced in any way when the patient is referred.

This is not a new position. Nova Scotian doctors have followed this for years when referring patients to other clinics. No clinic could exist on any other basis.

This difference has occurred in several clinics, but not as affecting many referring doctors.

One clinic experiences a major opposition in philosophy — i.e. in the question of the surgery of Mammary Carcinoma, but has elected to remain in the camp of the great majority of the better clinics of the world in the belief in Radical Mastectomy properly performed, as opposed to the very small majority who are still experimenting with Simple Mastectomy and Radiotherapy according to the doctrine of McWhirter.

There may be no doubt that in the not too distant future we may be experimenting in that realm too, but so long as the Radiotherapist remains completely unable to sterilize axillary nodes, so long will most men feel that within the limits of experience those nodes are better out. This writer was at Guys Hospital in October where there is an excellent Breast Service. They knew all about the McWhirter philosophy, but had not adopted it — nor indeed has any major clinic of our knowledge. Later he attended the International Cancer Congress in London where the McWhirter philosophy got short shrift in Dr. McWhirter's presence.

No one here denies any man the right to have views and to express them, but this clinic will not function except in the right of the men who are concerned with the patients that come to it, to treat patients according to what a preponderance of reason and their own experience has shown to be best for such patients, and this treatment will no doubt, under the impact of new knowledge vary from time to time.

## Followup

This by common consent, is a major function of the clinic. An objective of all cancer clinics is: never to lose sight of the patient. Contacts immediately after treatment must often be frequent and direct, later less frequent and direct, and finally may be indirect.

No clinician wants to pile up his free work unnecessarily so it must be assumed that when he says "2 months" or "6 months" for the patients return, the patients' interests, in his judgment, require that he or she should return. Again this is the practice in and around all the major clinics in different countries. In some, such as in Britain where large full-time staffs are maintained sub-clinics are held in thickly populated areas, and the men go to them from the central clinic. Manchester, for example, with a large portmanteau of records conduct such followup clinics, returning to the central clinic such patients as should have attention. In our more sparsely populated country that was considered and found impractical. Our voluntary system did not admit of it on any reasonable practical basis. Instead there developed the method of assisting patients to use the central clinic altogether by assuming the cost of transportation, etc. to and from the clinic for persons below a certain income. This has proved very valuable to the degree to which it has been applied, and without doubt cheaper than the other system would have been.

It is regrettable that despite the publicity that this clinic and others has tried to give to this aid, many people who need to come to clinic when given a date, say they can't afford to come. They hadn't heard of the transportation grant.

Followup is maintained by every means at the clinics disposal, (a) the patient, (b) the doctor, (c) relatives, (d) the clergymen and over the last year



or so (e) the very valuable assistance of the District Health Officer and his District Nurses.

The private doctor's hospital patients are followed for registry purposes only and are followed only through the doctor concerned, unless otherwise instructed by him. It is a well recognized fact that there are private patients whose followup is not adequate — by any standards.

### **The Tumour Registry**

So that reasonably good cancer statistics which are the more valuable as number of patients is greater, all cancer records of the clinic and hospital are included in the Tumour Registry and are followed as above. More than 6,000 case histories have now accumulated in the short time that the clinic has been in operation.

A Statistician has been employed who has been learning something of the application of statistics to Medicine.

An I.B.M. punch machine has just been installed and the work of processing these records has been begun. It is hoped that towards the end of the year something may emerge and the yearly report from that time will give comparative figures. There is no doubt that it will show up defects in the keeping of patients' records which is the bane of all those who attempt to produce reliable figures.

### **Present Status of Cancer Treatment**

Looking to the cure of cancer, nothing has happened to change the old principles: Surgery and Irradiation. The newer weapons in the realm of isotopes — valuable and all as they are — are simply refinements in the manner in which radiation may be applied. No discovery, no refinement in the techniques has in any important degree changed the major principle, though it has advanced and facilitated the approach and the more direct application. It is regrettable that our newspapers have to feature an article on an isotope centre in a New England city catering to Nova Scotia medical "trade" as if they had discovered some new principle in the cure of cancer. It is an article calculated to deceive the cancer sufferer who, in his extremity, will accept almost anything as gospel and on the strength of it will run to the ends of the earth, only to meet disappointment.

The Cobalt 60 Units should be in operation by the time this is printed. The early over-enthusiastic claims with respect to this great isotope have settled down to where more stable people knew it belonged. There is little doubt, but that to a very major degree, it will replace X-ray and that doses of its rays will be more penetrating than any X-ray machine that we have ever had. In all, it will be an infinitely better radiation machine from which much more effective work is being done, and it is a great step forward in the fight against cancer. The last word, however, remains as elusive as ever, and there is no room for advertising one centre more than another because it elects to use a competitive type of isotope. The writer has just visited the very excellent Cancer Centre in Oslo. Their major sources of radiant energy are Cesium and the Betatron. Results: the same.

Norman H. Gosse, M.D.,  
Director.

**INFECTIOUS DISEASES—NOVA SCOTIA**  
Reported Summary for the Month of August, 1958

Diseases	NOVA SCOTIA					
	1958		1957		1958	1957
	Cases	Deaths	Cases	Deaths	Cases	Cases
Brucellosis	0	0	0	0	0	0
Diarrhoea of Newborn	0	0	1	1	0	0
Diphtheria	0	0	0	0	2	17
Encephalomyelitis— Infectious	0	0	0	0	2	9
Food Poisoning	0	0	0	0	0	0
Gastroenteritis (1) Infectious	62	2	82	0	0	0
Hepatitis—Infectious Including Serum Hepatitis	34	0	9	1	0	0
Impetigo of Newborn	0	0	0	0	0	0
Influenza (if unusual number of cases)	128	0	593	2	343	869
Meningococcal Meningitis and Meningococemia	2	0	1	0	29	39
Pertussis	71	0	41	0	548	838
Poliomyelitis (paralytic (non-paralytic)	0 0	0 0	0 0	0 0	40 10	33 26
Scarlet Fever and Streptococcal Sore Throat	36	0	149	0	243	330
Tuberculosis (pulmonary non-pulmonary)	24 5	5 0	24 0	0 0	467 45	723 39
Typhoid and Paratyphoid Fever	0	0	0	0	45	19
Venereal Disease (syphilis) (gonorrhoea)	5 15	0 0	11 28	2 0	138 1218	166 1301
Anthrax	0	0	0	0	0	0
Cholera	0	0	0	0	0	0
Psittacosis	0	0	0	0	0	0
Rabies	0	0	0	0	0	0
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	0
Trichinosis	0	0	0	0	0	0
Tularemia	0	0	0	0	0	0
Other rare diseases	0	0	0	0	0	0
Other (if unusual number of cases)	0	0	0	0	0	0

(1) amoebic and bacillary dysentery and salmonellosis

## Eczema Vaccinatum

During the month of September, two cases of Eczema Vaccinatum occurred in children in the City of Halifax. Neither child had been vaccinated, but one sibling had been vaccinated against smallpox. Both children were treated at the Infectious Diseases' Hospital and both recovered.

It was thought worthwhile at this time to bring to the attention of the medical profession an article which appeared in the August, 1958, issue of Pediatrics by Audrey H. Renolds, M.D., and Howard A. Joos, M.D., Department of Pediatrics, University of Southern California and the Children's Hospital of Los Angeles. The article describes in detail two recent cases resulting from contact between children with atopic eczema and recently vaccinated siblings and it summarizes seven additional cases from the files of the Children's Hospital of Los Angeles. According to this article the incidence of this disease may be anywhere between 1 in 20,000 and 1 in 100,000 vaccinations and the death rate may be anywhere between 4% and 40%. There were two deaths in the nine cases described. The following is a summary of the article:

"Nine cases of eczema vaccinatum are presented, including two fatalities. Seven were caused by contact of a child with eczema with a recently vaccinated sibling.

"Suddenly appearing umbilicated vesicles superimposed upon atopic eczema are almost diagnostic of eczema vaccinatum or eczema herpeticum. These do not occur with mere secondary bacterial infection.

"Hyperimmune vaccinal gamma-globulin is now available for specific therapy.

"Eczema vaccinatum is frequently iatrogenic and uniformly preventable.

"The following steps are recommended for prophylaxis: 1) No child with atopic eczema or other skin disorder should be vaccinated. 2) No child should be vaccinated if any member of his family has eczema or other skin disorder. 3) Parents of children with eczema should be notified at the onset of the disease of the danger from vaccination contact. 4) If a sibling of a child with atopic eczema is vaccinated, he must be completely separated from that child at least 21 days. 5) Forms used by state and local health departments for parents' consent to vaccination should include an appropriate warning of the contraindications. 6) Eczema vaccinatum should be a reportable disease. 7) Patients recently vaccinated must be excluded from pediatric wards containing patients with atopic eczema, other diseases of the skin, burns or healing surgical incisions. 8) Vaccination may be recommended at 2 months of age, especially for babies from strongly allergic families."

### Remarks

**Re: Distribution of biologicals by the Provincial Department of Public Health free of charge**

This is to advise all doctors in the Province that they may obtain smallpox vaccine and other biological products from the Divisional Offices and, in the case of the City of Halifax, from Dr. A. R. Morton, Commissioner of Health

for the City. This has been the procedure in the past, but still a great many doctors are requesting these materials directly from the Central Office in the Provincial Building in Halifax. If, however, on occasions, it should prove very inconvenient for doctors to procure these materials locally, they may, of course, obtain them from the Central Office. The names and addresses of the Divisional Medical Health Officers are as follows:

Dr. G. M. Smith, P.H.D.,  
Div. Medical Health Officer,  
Box 1210, Windsor, N. S.

Dr. J. R. Cameron, P.H.D.,  
Div. Medical Health Officer,  
Box 8, Dartmouth, N. S.

Dr. W. I. Bent, D.P.H.,  
Div. Medical Health Officer,  
Box 230, Bridgewater, N. S.

Dr. V. K. Rideout, D.P.H.,  
Div. Medical Health Officer,  
253 Main St., Yarmouth, N. S.

Divisional Medical Health Officer,  
Box 40,  
Truro, N. S.

Divisional Medical Health Officer,  
Box 310,  
Pictou, N. S.

Dr. D. G. McCurdy, D.P.H.,  
Div. Medical Health Officer,  
Box 460, Sydney, N. S.

Dr. N. F. Macneill, D.P.H.,  
Div. Medical Health Officer,  
Box 460, Sydney, N. S.

In the City of Halifax, Dr. A. R. Morton distributes biologicals from the Infectious Diseases' Hospital, University Avenue.

The following is a list of biologicals which may be obtained from the above mentioned sources free of charge by signing the required form. This form states that the materials will be administered to the patient free of charge or at a reduced rate:

Diphtheria Toxoid, 1 person, 3 x 1 cc ampoules

Diphtheria Toxoid, 6-6 cc (12-18 persons)

Diphtheria Toxoid, Dilute, 3 x 1 cc ampoules

Schick test for testing 25 persons

Diphtheria Toxoid & Pertussis Vaccine, combined, 3 x 1 cc amps.

Diphtheria Toxoid & Pertussis Vaccine, combined, 6 x 6 cc amps.

Pertussis Vaccine, 3 x 1 cc ampoules (1 person)

Pertussis Vaccine, 6 x 6 cc ampoules (6 persons)

Smallpox Vaccine, 1 point package

Smallpox Vaccine, 5 point packages

Smallpox Vaccine, 10 point packages

Tetanus Toxoid, 1 person 3 x 1 cc ampoules

Tetanus Toxoid, 30 cc vial

Typhoid-Paratyphoid Vaccine, 1 person — 3 ampoules

Typhoid-Paratyphoid Vaccine, 5-7 persons — 10 cc

Diphtheria Toxoid, Pertussis Vaccine & Tetanus Toxoid combined,  
1 person 3 x 1 cc amps.

Diphtheria Toxoid, Pertussis Vaccine & Tetanus Toxoid combined,  
9 persons

Diphtheria Toxoid and Tetanus Toxoid, combined, 3 x 1 cc amps.

Diphtheria Toxoid and Tetanus Toxoid, combined, 9 persons

Poliomyelitis Vaccine may also be obtained from these same sources under the conditions set forth in the Release concerning Distribution of Poliomyelitis Vaccine Free of Charge by the Department of Public Health which was distributed to all doctors in the Province in April, 1958.

THE DEPARTMENT OF PUBLIC HEALTH DOES NOT SUPPLY ANTITOXINS FREE OF CHARGE.

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### ONE THIRD OF SICK PEOPLE DON'T GET THEIR MEDICINE

SWAMPSCOTT, Mass. (June 16)—One-third of the sick people don't get their prescribed medicines for one reason or another, a drug leader said today.

Lee L. Gibson, vice president of Lakeside Laboratories of Milwaukee said "this unfilled prescription problem should attract the attention of all members of the health team, physicians, pharmacists and manufacturers alike."

He spoke at the annual convention of the Massachusetts Pharmaceutical Association.

The authority for his statement were two intensive studies in four South-eastern cities and the Midwest. In the first, doctors, druggists and patients were interviewed personally to learn why an average of 31 out of 100 prescriptions were lost. While sometimes the pharmacist did not have the prescribed drug in stock, many cases were the fault of patients.

Often a patient sick at night received a prescription from his doctor and then "felt better" in the morning and didn't even go to the druggist, the study showed.

In some cases patients even recognized the prescription and went against their doctor's orders because they "didn't believe in the drug."

# Eighth Annual Meeting

CANADIAN PUBLIC HEALTH ASSOCIATION

ATLANTIC BRANCH

CORNWALLIS INN, KENTVILLE, NOVA SCOTIA

NOVEMBER 19, 20, 21, 1958

## CONVENTION INFORMATION

Registration and Information Service will be at Convention Headquarters, the Cornwallis Inn, Kentville, and will be open Tuesday evening, November 18, 1958, from 8:00 to 10:00 p.m.

## PROGRAMME

Tuesday, November 18, 1958

3:00 p.m. Meeting of the Executive

Wednesday, November 19, 1958

8:30 a.m. Registration

9:30 a.m. Address of Welcome — J. C. Wickwire, M.D.

9:40 a.m. "Nova Scotia's Hospital Insurance Programme"  
G. G. Simms, M.D., D.P.H.

10:15 a.m. "The Place of Occupational Health in Public Health Services"  
T. H. Patterson, M.D., D.P.H., Chief, Occupational Health Division, Department of National Health and Welfare, Ottawa

10:45 a.m. Coffee

11:00 a.m. "Air Pollution"  
R. Donald McKay, P.Eng., Director, Division of Environmental Hygiene, N. S. Department of Public Health

11:30 a.m. Panel on "Behaviour Problems in Children"  
Moderator: Clyde Marshall, M.D.  
F. A. Dunsworth, M.D., D.A.B. Psy., Associate Professor of Psychiatry, Dalhousie University  
Henry Ross, M.D., Associate Professor of Paediatrics, Dalhousie University  
Miss Marjorie A. Cook, M.A., Director of Special Services, Special Services Department, Board of School Commissioners, Halifax

- 2:30 p.m. Sectional Meetings
1. Sanitation — Valley Room
  2. Occupational Health — Cornwallis Room
  3. Nutrition and Child and Maternal Health — Ball Room

6:45 p.m. Reception — Cornwallis Room

7:30 p.m. Annual Dinner — Ball Room  
 Courtesy the Department of Public Health of  
 Nova Scotia

Speaker: Thomas H. Raddall  
 Guest Soloist: Karen Kierstead Mills  
 Guest Accompanist: Madeline Dexter Keay

Thursday, November 20, 1958

Chairman: J. E. Hiltz, M.D.

- 9:15 a.m. "Accidental Poisoning in Childhood"  
 P. M. Sigsworth, M.D.
- 9:45 a.m. "The Dental Hygienist Programme"  
 W. Gordon Dawson, D.D.S., D.D.P.H., Director,  
 Division of Dental Services, N. S. Department  
 of Public Health
- 10:15 a.m. "Trends in the Treatment of Cancer"  
 Norman H. Gosse, M.D., D.Sc., F.A.C.S., F.R.C.S.(C),  
 Director, N. S. Tumour Clinic, Victoria General Hospital  
 and Associate Professor of Surgery, Dalhousie University
- 10:45 a.m. Coffee
- 11:00 a.m. "Crippled Children's Clinics"  
 Daniel J. Rooney, M.S.W., Executive Director,  
 N. S. Society for the Care of Crippled Children
- 11:30 a.m. Business Meeting
- 2:30 p.m. Section on Chest Diseases
- 4:30 p.m. Tea at the Nova Scotia Sanatorium
- 8:30 p.m. Pageant "A Half Century of Public Health in Nova Scotia"  
 Acadia University Auditorium

Friday, November 21, 1958

Chairman: C. E. van Rooyen, M.D.

- 9:15 a.m. "Modern Cardiovascular Diagnosis"  
 S. J. Shane, M.D., F.C.C.P., F.A.C.P., F.R.C.P.(C),  
 Medical Director, Halifax Tuberculosis Hospital, and  
 Assistant Professor of Medicine, Dalhousie University

- 9:45 a.m. "Oral Treatment of Diabetes"  
D. J. Topping, M.D., F.A.C.P., Associate Professor of  
Medicine, Dalhousie University
- 10:15 a.m. "Prevention and Control of Staphylococcal Infections  
In Hospital"  
E. M. Fogo, M.D., D.P.H., Director of Communicable  
Disease Control, City of Halifax
- 10:45 a.m. Coffee
- 11:00 a.m. "Immunization Status of High School Children — Schick  
Test Survey"  
G. M. Smith, M.D., D.P.H., Divisional Medical Health  
Officer, N. S. Department of Public Health, Windsor

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### FOR SALE

We are offering for sale the office equipment of Doctor James A. Muir, late of Truro, N. S., which includes medical supplies, instruments, medical books, and office furnishings. List available on request.

The Acadia Trust Company, Executive,  
Truro, Nova Scotia.

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### RESULTS OF SURGERY FOR PULMONARY CANCER\*

The late results of 94 consecutive pulmonary resections for primary carcinoma of the lung performed before August 31, 1952, are analyzed.

Of 94 patients who underwent pulmonary resection, pneumonectomies were performed on 73 and lobectomies on 21.

A five-year-or-longer survival resulted in 17 patients. Of 12 pneumonectomies and 5 lobectomies, all but one remained free of cancer. One of these 17 patients developed a primary carcinoma of the thyroid gland nine years after the pulmonary resection.

Surgical exploration is justified in the face of a solitary, small, circumscribed, persistent, nodular shadow of the lung.

Radical or enlarged pneumonectomy may be of help in many cases even for so-called "incurable cases."

Lobectomy has a definite place in the treatment of cancer of the lung. Good surgical treatment aided by modern diagnostic methods are the best guides to appropriate therapy.

Taiana, J. A., *Journal of the International College of Surgeons*. 28: 691-703, 1957.  
\*From Medical Abstracts, December, 1957.



**THE B.M.A. — C.M.A. MEETING  
EDINBURGH — JULY 18-24TH, 1959.**

The following Bulletin has been prepared by Mr. Ray Bowman, Maritime Travel Service.

University Tours of Toronto is making arrangements for accommodation, and if desired additional tours. The Application form has appeared in The Canadian Medical Association Journal and may be obtained on request.

The Maritime Travel Service is affiliated with University Tours and the purpose of the Bulletin is to give physicians information about travel facilities.

C. J. W. B.

**BULLETIN FOR CMA MEETING JULY 1959 EDINBURGH**

Prepared by Maritime Travel Service  
76 Granville St., Halifax, N. S.

**Travel Documents**

**Valid Passport**

(Application forms will be mailed on request. Fee \$5.00)

**Certificate of Vaccination**

For smallpox valid within three years of your return date to Canada

<b>Visas Required</b>	Portugal	\$3.65
<b>Visas</b>	Spain	5.11

**Not Required**

United Kingdom — France — Ireland — Belgium — Holland —  
West Germany — Austria — Switzerland — Italy — Denmark —  
Sweden — Norway — Luxembourg

**Car Hire**

No additional application for permit to drive required in Belgium —  
France — United Kingdom — Ireland — Italy — Switzerland —  
Luxembourg — Norway — Sweden — Denmark  
Your Provincial Operators permit is acceptable

**Hotels**

Other than convention city of Edinburgh — may be arranged in  
advance — but early application must be made

**Tours**

Tours of your choice ranging from five to sixty days covering the  
Continent — United Kingdom — Ireland are available.

**Surface Transportation**

Service from **Halifax** is limited to Bi-Monthly Furness Line de-  
partures to Liverpool via St. John's Newfoundland.

Service from **Montreal — Quebec — New York** is available  
weekly on Canadian Pacific — Cunard — Home Lines — Arosa  
Line — Holland American Line — and others with occasional sail-  
ings direct to Greenock (Glasgow)

**Rates**

Vary according to steamer tonnage but generally for the summer  
season from Halifax will commence at \$230.00 per passenger First  
Class each way and Tourist Class at \$169.00 per passenger each way.  
While from **Montreal — Quebec — New York** — due to larger  
vessel tonnage — the minimum First Class fare is \$315.00 per passen-

ger each way and approximately \$200.00 per passenger Tourist Class each way. Rates to France are slightly higher due to Port Taxes. **Children** under 12 years half fare.

Steamship companies are again refusing to accept one way traffic during July and August and September **Westbound** — however should you desire to travel **Eastbound** by steamer we can provide return by airline if desired.

### **Airline Transportation**

Trans Canada — British Overseas Airways — K.L.M. — Lufthansa — Swiss etc. are available with service of approximately 10 flights daily to Glasgow — Manchester — Shannon — London — Paris — Amsterdam — Brussels — Zurich — Dusseldorf at the following fares:

#### **Halifax/Montreal/London**

<b>Deluxe Class</b>	One Way	\$471.00
	Return	847.80

Free baggage allowance is **66 lbs.**

<b>First Class</b>	One Way	\$421.00
	Return	757.80

Free baggage allowance is **66 lbs.**

<b>Economy Class</b>	One Way	\$247.00
	Return	444.60

Free baggage allowance is **44 lbs.**

#### **Halifax/Montreal/Glasgow**

<b>Deluxe Class</b>	One Way	\$452.00
	Return	813.60

<b>First Class</b>	One Way	\$402.00
	Return	723.60

Free baggage allowance is **66 lbs.**

<b>Economy Class</b>	One Way	\$232.00
	Return	417.60

Free baggage allowance is **44 lbs.**

#### **Halifax/Gander/Glasgow**

<b>Deluxe Class</b>	One Way	\$435.00
	Return	787.40

<b>First Class</b>	One Way	\$385.00
	Return	697.40

Free baggage allowance is **66 lbs.**

<b>Economy Class</b>	One Way	\$212.00
	Return	388.60

Free baggage allowance is **44 lbs.**

Flights via Gander are limited to three per week on TCA and BOAC — however if a group of 15 desire to use this routing we can arrange for addition stop at Halifax or Gander for passengers from this area.

The routing via Montreal is desirable in many ways owing to the numerous flights daily non stop

There are many combination fares to choose from —

#### EXAMPLE I

##### Halifax/Montreal and Return —

Shannon — Dublin — Birmingham — London — Amsterdam — Brussels — Paris — London — Edinburgh — Glasgow

**Economy** \$480.60

Free Baggage allowance 44 lbs.

#### EXAMPLE II

##### Halifax/Montreal and Return —

Shannon — Dublin — Birmingham — London — Paris — Brussels — Amsterdam — Frankfurt — Dusseldorf — Zurich or Geneva — London — Manchester — Glasgow

**Economy** \$513.20

Free Baggage allowance 44 lbs.

#### EXAMPLE III

##### Halifax/Montreal and Return —

Shannon — Dublin — London — Amsterdam — Brussels — Paris — Zurich — Geneva — Nice — Rome — Milan — Stuttgart — Frankfurt — Glasgow

**Economy** \$582.50

Free Baggage allowance 44 lbs.

#### EXAMPLE IV

##### Halifax/Montreal and Return —

Shannon — Dublin — Manchester — London — Amsterdam — Brussels — Paris — Geneva — Zurich — Frankfurt — Hamburg — Copenhagen — Glasgow

**Economy** \$513.20

Free Baggage allowance 44 lbs.

#### First Class Fares WILL BE PROVIDED ON APPLICATION

##### British Rail Travel Coupons

**First Class** . . . . . 1000 Miles of travel . . . . . \$30.00

**Second Class** . . . . . 1000 Miles of travel . . . . . \$20.00

Obtainable only in Canada

These coupons are available for use for Pullman reservations as well as channel crossings between United Kingdom and Ireland.

We shall be pleased to attend to any reservations you may require at the rates quoted by the Carrier — We make no additional charge of any kind for our services.

Please do not hesitate to write or call us for further information which we shall be pleased to provide without obligation.

MARITIME TRAVEL SERVICE.

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### **SALICYLATES AND GLUCOCORTICOIDS IN THE TREATMENT OF RHEUMATOID ARTHRITIS\***

The immediate anti-inflammatory activity, as manifested by the serum protein-bound polysaccharide-protein ration (PR), of various glucocorticoids, glucocorticoid-salicylate combinations and salicylates has been compared in patients with rheumatoid arthritis.

Salicylates in tolerable doses were found to exert a significant though modest antirheumatic effect. The addition of small amounts of glucocorticoids to the salicylates produced no objective evidence of drug reinforcement.

Prednisolone exhibited approximately five times the anti-inflammatory potency of cortisone insofar as the production of changes in PR and prednisone proved slightly less effective than prednisolone in this regard.

Payne, R. W., Dhetlar, M. R., Hellbaum, A. A., and Ishmael, W. K., Journal of the Oklahoma State Medical Association. 50: 498-500, October, 1957.

\*From Medical Abstracts, December, 1957.

## Society Meetings

### ANTIGONISH-GUYSBOROUGH MEDICAL SOCIETY

A meeting of the Antigonish-Guysborough Branch of the Nova Scotia Division of The Canadian Medical Association was held at St. Martha's Hospital, Antigonish, on Sunday, September 14th, 1958. Thirteen members were present who were pleased to welcome Doctor C. J. W. Beckwith, Executive Secretary of the Division.

After the completion of routine business, the meeting considered suggestions from the Registrar General for improving the statistics derived from Death Certificates. Attention was drawn to the difficulties which might arise if office records were not available when the certificate was completed, because, among other things, information was required about the date of first attendance and the duration of the final illness. Mention was also made of the necessity of referring certain cases to the Coroner when the interval between the last attendance and the death of the patient was prolonged. With these reservations in mind, members pledged their co-operation.

There was a lengthy discussion on the implementation of the 1958 Fee Schedule. Rural members reported that fees for brief first consultations and some follow up calls had to be reduced because of economic difficulties in the area. It was also noted that in both rural and urban areas there were many obstetric patients who preferred to pay for their care with a fee for each visit and a fee for the delivery rather than with an all-inclusive fee. In general it appeared that the physician received approximately the same remuneration for his service, whether the fees were in instalments or as a lump sum.

The fees payable by the Workmen's Compensation Board were discussed. It was understood that the Board had a copy of the 1958 Fee Schedule for consideration. It was considered that pro-ration of fees for official bodies was inequitable because of the amount of extra work required in completing reports; however, it was pointed out that the Department of Veterans Affairs allows a fee to be charged for making a report in addition to the fee payable for service to the patient.

The meeting felt that there could be no objection to doctors reducing fees at their discretion in selected cases, provided the fact that a reduction was being made from the Fee Schedule was brought to the attention of the patient.

There was lengthy consideration of some of the problems surrounding the physical examination of applicants for Disability Pensions. Apart from the difficulty in collecting a fee for such an examination from persons who were more likely than not to be indigent, it was felt that the doctor and the fee payable were being used as deterrents, and there were grounds for suspicion that unsuccessful pension applicants were blaming the doctor for their failure to qualify for a pension. It was considered that the Department of Welfare should either assume responsibility for paying the fee for these examinations or employ its own examining physician. A motion to this effect was carried.

Suggestions were received for improving the liaison between referring doctors and consultants within the Branch area and it is hoped that administrative steps will make it possible to achieve this with the co-operation of the Record Departments of the hospitals.

Doctor Beckwith made some helpful observations on the proposed alterations in the Group Insurance Scheme and also on the working of the Tumour Clinic.

After votes of thanks to the Sisters of St. Martha's for their hospitality and to Doctor Beckwith for his attendance, the meeting adjourned to dinner in the hospital dining room.

A. J. M. Griffiths, Secretary.

### HALIFAX MEDICAL SOCIETY

The business part of the Annual Meeting was held at the Dalhousie Public Health Clinic on April 30th, and the Annual Meeting at the Lord Nelson Hotel on May 6th when a most enjoyable Dinner Dance took place.

The following officers and Executive were elected for the year 1958-59.

President —Doctor A. M. Marshall, Halifax.

President-elect—Doctor J. W. Merritt, Halifax.

Secretary —Doctor H. C. Still, Halifax.

Treasurer —Doctor R. W. M. Ballem, Halifax.

Executive —Doctors F. A. Dunsworth, A. B. Crosby, G. W. Bethune, R. M. MacDonald and A. J. R. Brady of Halifax and Doctor W. M. D. Robertson of Dartmouth.

Nominations for Nominating Committee of The Medical Society of Nova Scotia—

—Doctor D. M. MacRae, alternate Doctor F. A. Dunsworth, both of Halifax.

Nominations to the Executive of The Medical Society of Nova Scotia—

—Doctors A. M. Marshall, J. W. Merritt, F. A. Dunsworth, all of Halifax.

Alternates —Doctors R. M. MacDonald and A. J. R. Brady of Halifax, and Doctors W. M. D. Robertson of Dartmouth.

Mediation Committee of Halifax Medical Society—(Chairman) Doctor E. F. Ross, Doctors F. M. Fraser and J. W. Reid, all of Halifax.

H. C. Still, Secretary.

### WESTERN NOVA SCOTIA MEDICAL SOCIETY

The Western Nova Scotia Medical Society met in annual session, with their wives, at Braemar Lodge on the evening of September 25th. Forty-six were in attendance. Following a social hour, dinner was served in the main dining room and we were favoured with a very interesting and instructive after dinner talk by Doctor W. A. Taylor of Halifax, who was introduced by Doctor Rideout. Doctor Taylor spoke particularly on the National Health Service in the United Kingdom and his comments were well received both by the doctors and their wives. Then they adjourned to another building for

the business meeting under the chairmanship of the President, Doctor D. S. Robb. The following slate of officers were elected on motion:

President	—Doctor P. H. LeBlanc, Little Brook
Vice-Presidents	—Doctor M. F. Taylor, Barrington Passage —Doctor Robert P. Belliveau, Meteghan —Doctor W. M. Phinney, Yarmouth
Secretary	—Doctor D. F. Macdonald, Yarmouth
Treasurer	—Doctor R. M. Caldwell, Yarmouth
Member Nominating Committee	The Medical Society of Nova Scotia— —Doctor Milton W. O'Brien, Tusket; alternate —Doctor Gerald D. Belliveau, Yarmouth
Member Nominated to Executive	The Medical Society of Nova Scotia— —Doctor D. R. Campbell, Shelburne; alternate —Doctor Milton W. O'Brien, Tusket
Mediation Committee	—Doctors P. E. Belliveau, Meteghan; W. C. O'Brien, Yarmouth; C. K. Fuller, Yarmouth
Nominee to M.M.C. Directorate	—Doctor D. F. Macdonald, Yarmouth.

The next item of business provoked a very long discussion and concerned the new schedule of fees. Doctor Beckwith representing The Medical Society of Nova Scotia and Doctor Shaw, representing M.M.C. both stated their opinions regarding the schedule and several other members entered into the discussion. It seemed to be the general impression that M.M.C. should develop a schedule, on the basis of which, they would be able to pay 100 per cent or at least 90 per cent, with regularity. Doctor Burton spoke very emphatically in favour of M.M.C. and the benefit it has been to the G.P. and his comments seemed to express the tenor of the meeting. This particular item of business terminated with a motion by Doctor Webster to the effect that we go on record as being favourable to M.M.C. and its operation; that we endeavour to work out a schedule suitable to both M.M.C. and The Medical Society of Nova Scotia and an effort be made to bring M.M.C. to more people including the smaller groups.

Another lengthy discussion followed regarding a request from the March of Dimes, that they be able to put on a free clinic in this area. We noted the motion made by the Executive of The Medical Society of Nova Scotia endorsing in principle, but not favourable to private patients taking advantage of the free clinic. However, it was felt that public relations would suffer should we turn down this offer and for this reason the meeting agreed to cooperate with the clinic. Considerable dissatisfaction was expressed concerning the publicity put out by the March of Dimes and it is thought that the doctors place in the effort was too much submerged.

Doctor Robb then welcomed Doctor James Mallett of West Pubnico and Doctor Felix Doucette of Weymouth who have just recently commenced practices in the area.

During this period the ladies enjoyed Bridge and general conversation in another room and our meeting terminated at a late hour on motion.

D. F. Macdonald, M.D.,  
Secretary.

## Personal Interest Notes

Doctor T. E. Kirk, Superintendent and senior treatment medical officer at Camp Hill Hospital, Halifax, was awarded a Fellowship from the American College of Hospital Administrators at Chicago on August 17, 1958. This Fellowship is granted to individuals who have had training and extensive experience as hospital administrators.

Doctor S. J. Shane, Associate Professor of Medicine (Dalhousie) has been appointed as a member of the Committee on Non-surgical and Drug Therapy of the American College of Chest Physicians. This Committee serves under the Council on Research of the College.

Doctor James C. Vibert, who has been a fellow in surgery in the Mayo Foundation in Rochester, Minnesota, has left that city and will be located in Truro, N. S.

The Annual Meeting of the Nova Scotia Association of Radiologists was held at the Victoria General Hospital, Halifax, on April 20, 1958. The new slate of officers elected was as follows: President, Doctor H. R. Roby, Windsor; Vice-President, Doctor J. S. Manchester, Halifax; Secretary-Treasurer, Doctor Richard H. James, Halifax; Directors, Doctor H. R. Corbett, Sydney; Doctor R. E. Price, Amherst, and Doctor R. B. Miller, New Glasgow.

Doctors E. F. Ross, N. H. Gosse and J. A. McCarter of Halifax, together with Doctor R. A. Moreash of Berwick attended the 7th International Cancer Congress in London, England, during the month of July.

Doctor James F. Hammerling of Halifax has returned after completing a six week course in the surgery of deafness sponsored by that specialty in New York City.

Doctor and Mrs. D. K. Murray of Halifax have returned from a five week tour of Europe. During this trip Doctor Murray attended a meeting of the American College of Surgeons held at Stockholm.

Doctor and Mrs. S. B. Bird of Liverpool have returned from an European holiday together with their two children, Carolyn and John, and Mrs. Bird's father, Mr. A. W. Nickerson of Halifax.

Doctor N. B. Coward of Halifax has returned from a visit to his parents Rev. and Mrs. F. W. Barrie Coward of Camberley, Surrey, England.

Word has been received that Doctor D. James Sieniewicz, son of Doctor and Mrs. T. M. Sieniewicz of Halifax, has been appointed Chief Radiologist at the Montreal General Hospital and also has been appointed Associate Professor of radiology at McGill University.

Doctor Sieniewicz graduated from Dalhousie University in 1950 and interned at the Victoria General Hospital. He studied radiology at the Peter Bent Brigham Hospital and the Toronto General Hospital before moving to Montreal.



Several appointments have been announced recently to the staff of Dalhousie Medical School, the Victoria General Hospital, the Children's Hospital, and the Grace Maternity Hospital, including the first geographic full-time staff members in the Department of Obstetrics and Gynaecology and the Department of Paediatrics, and the first full-time Pathologist in the Children's Hospital.

Doctor Carl Tupper of Halifax has been appointed Professor of Obstetrics and Gynaecology at Dalhousie University and Head of the Department of Gynaecology at the Victoria General Hospital. Doctor Tupper has been Associate Professor at Dalhousie since 1956. He is a Dalhousie graduate with the degrees B.Sc., 1939 and M.D., C.M., 1943. He also holds the specialist Certificate of the Royal College of Physicians and Surgeons of Canada and is a Fellow of the American College of Surgeons, Fellow of the International College of Surgeons, and Fellow of the American College of Obstetricians and Gynaecologists.

Doctor Tupper was born in Stellarton, Pictou County, and received his early education there and in New Glasgow. He spent one year of study at the Provincial Normal College at Truro and was a teacher for one year before returning to University for pre-medical and medical training. After graduation he served for three years as a Captain in the Royal Canadian Army Medical Corps in Europe, and then returned to post-graduate study in Halifax and various American centres. He joined the staff of Dalhousie University in 1950.

Doctor Tupper has gained an excellent reputation both in his specialty of Obstetrics and Gynaecology and as a medical teacher. For the past five years he has also been one of the key members of a co-operative research team which has been studying the causes of abortion. Several important articles and reports have been published by Doctor Tupper and his associates on this subject.

Doctor Tupper will continue a limited practice in Obstetrics and consulting practice in Gynaecology, but will devote the major part of his time to the teaching and clinical work in the University and affiliated hospitals.

Doctor Tupper succeeds Doctor H. B. Atlee who has been appointed Professor Emeritus.

In the Department of Paediatrics Doctor N. Barrie Coward has been appointed Professor succeeding Doctor G. B. Wiswell who has been appointed Professor Emeritus.

Doctor Coward is a graduate of the 1928 class of Dalhousie Medical School. He spent three years in post-graduate study at the Hospital for Sick Children, and the Riverdale Hospital for Infectious Diseases in Toronto, one year at Bellevue Hospital, New York and one year in Edinburgh, Birmingham, Glasgow and Great Ormond Street Hospital for Sick Children, London. He returned to Halifax in 1933 where he has since practised his specialty and has served on the staff of the Hospital and University. He holds the specialist Certificate in Paediatrics of the Royal College of Physicians and Surgeons of Canada and is a Fellow of the American Academy of Paediatrics.

Doctor Coward's appointment is on a part-time basis and he will continue his practice.

Doctor William A. Cochrane has been appointed as Associate Professor of Paediatrics and Associate Physician in the Children's Hospital on a geographic full-time basis. He has been a consulting paediatrician in Toronto and a member of the Department of Paediatrics of the University of Toronto, and the Hospital for Sick Children. He is a graduate of the University of Toronto, 1949, and has done post-graduate study since that time in Pathology and Paediatrics at the Hospital for Sick Children for three years, the Cincinnati Children's Hospital for one year, Great Ormond Street Sick Children's Hospital, London, England, for one year, and two six-month periods in Medicine at the Toronto East General Hospital, and in Surgery at the Peter Bent Brigham Hospital at Harvard Medical School. He holds the Certificate in Paediatrics of the American Board of Paediatrics and is a Fellow of the Royal College of Physicians and Surgeons of Canada.

Doctor Cochrane has done considerable research work in several fields of Paediatrics, especially those having to do with Childhood diabetes and with pyridoxine metabolism in convulsions and mental deficiency in infants. He is also interested in the application of radio-active isotopes and their relation to electrolyte physiology in certain diseases of children. He has received grants from the Banting Foundation and the National Research Council for these studies.

The first full-time post in Pathology at the Halifax Children's Hospital has been established jointly by the Hospital and University and the post has been filled by Doctor Kurt Aterman. Doctor Aterman has an M.D. degree from Charles University, Prague, and M.B., Ch.B., Queens University, Belfast. He also holds the M.R.C.P. (Lond.), and Diploma in Child Health (Lond.). After graduation he spent two years in Paediatrics at the Hospital for Sick Children, Great Ormond Street, London. During two years service in the Royal Army Medical Corps in India, he received his early training in Pathology which he continued in West Middlesex Hospital, London, from 1946-48. He then spent two years as a Commonwealth Fellow at Harvard Medical School and the University of Chicago, and returned in 1957 to the University of Chicago on a research fellowship. He came to Halifax from the University of Birmingham Medical School.

Doctor Aterman has an extensive list of publications from 1950 to date which number more than twenty. He will spend approximately one-third of his time in the Department of Pathology of the University and the remainder in organizing and operating the clinical pathology services for the Children's Hospital.

## Obituaries

Florence Maud O'Donnell Piers, M. D., age eighty-two, passed away on September 29, 1958, while a patient in the Victoria General Hospital.

Dr. Piers was born in Halifax and attended the Halifax County Academy and Dalhousie University where she received her M.D. in 1901. Her early professional life was spent at Chengtu, Central China, as a medical missionary. She returned to Canada in 1908 and married William Harrington Piers of Halifax. Following her marriage she retired from medical practice.

Dr. Piers was predeceased by her husband who died in 1939, and one brother, John Dunlap O'Donnell. She was a member of St. Matthews Church, the Princess Louise Chapter I.O.D.E., the Halifax Golf and Country Club, the Chester Golf Club and the Chester Yacht Club. She is survived by three children, Walter McLaren Piers, Commodore Desmond William Piers, R.C.N., Mrs. Emily B. Finch-Noyes, wife of Commodore Edward William Finch-Noyes, R.C.N., and two sisters, Mrs. A. E. O'Donnell of Halifax, and Mrs. A. F. Grady of Fort McLeod, Alberta. She is also survived by eight grand children.

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Dr. Frank John McLeod, age fifty-five, of Inverness, Cape Breton, died at his home on September 18, 1958. Dr. MacLeod graduated from Dalhousie University in 1925, and opened his first practice at Maitland. For a brief period he practised in Sydney, Cape Breton, but had spent the last thirty years at Inverness. His special interest was that of general surgery. Dr. MacLeod was born at St. Ann's, C.B., in 1903. His primary education was at St. Ann's and Baddeck, and later at the Sydney Academy. He entered Dalhousie Medical College in 1920. Following his graduation he interned at the Victoria General Hospital and did post-graduate work at the Royal Victoria Hospital at Montreal.

Throughout his professional life he was interested in community affairs and in the development of the Inverness Memorial Hospital. He was a Fellow of the American College of Surgeons, a member of St. Matthews United Church, and the Masonic Lodge.

He is survived by his wife, Margarie Putnam MacLeod, one son, David of Halifax two daughters, Dr. Ann Vogel and Louise, both at home, and four brothers.

"For a little while we knew him,

"Such a little while;

"But we never shall forget him,

"Nor his gentle touch or smile."

(Mrs. Elizabeth Devouge, Inverness)

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Doctor James Alexander Muir of Truro, aged 53, died August 28th while a patient at the Victoria General Hospital, Halifax. He was a graduate of Pictou Academy and Dalhousie Medical School and received his B.Sc. and M.D., C.M. from the latter institution. Following his graduation he practised medicine at Port Hawkesbury until 1939 when he joined the Army Medical Corps and served in Italy and North Africa. In 1945 he returned to Canada

and was posted to Debert Hospital where he was officer commanding with the rank of major. For his services with the medical corps he was awarded the efficiency decoration.

Returning to civilian life Doctor Muir set up practice in Truro in 1946. Besides his general practice he was a specialist in diseases of the heart and was lately elected Vice-President of the Colchester-East Hants Medical Society.

During his life he was active and interested in sport activities. During his college days he won the one mile race a record which was not broken until last year.

He is survived by his wife, the former Jean Robb of Bedford, five children, Helen and James attending Dalhousie University, Margaret, Gordon and Donald at home, two brothers, Dr. Everett Muir, Salt Lake City and Dr. Robert K. Muir, Toronto, three sisters, Margaret (Mrs. (Rev.) Ward H. MacLean), Halifax; Miss Elsie Muir, R.N., New York now at Eureka, and Della, (Mrs. Elbridge Cameron) of Eureka.

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Doctor John Inglis Haliburton Laurie, M.A., M.R.C.S., L.R.C.P., M.B.C.H. aged 46, died on September 9th. in Montreal. He was the only son of Lt. Col. and Mrs. K. C. Laurie of Oakfield, N. S. Doctor Laurie was educated in England and received his medical training at Cambridge University. He spent five years in Cyprus, serving in the British Colonial Medical Service. He later joined the Canadian Army Medical Corps as a captain and served in England, and later with UNRRA in Western China, and was also in charge of Red Cross hospitals in Hamburg Germany. He was a former medical officer in charge of Point Edward Hospital, Cape Breton, and organized its conversion from a naval to a civilian tuberculosis hospital.

Since 1951 he had been Medical Director of Merek and Company, Limited, for Canada.

He is survived besides his parents by his widow, Audrey, daughter of Dr. and Mrs. K. Hollis, Toronto, and three children, also a sister, Iris, wife of Admiral B. R. Spencer, R.C.N., Ottawa.

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Doctor Roland Ruf of Eastern Passage, died at his home on September 6th, 1958. Born in Germany Doctor Ruf had emigrated to Canada a few years ago. He spent a year's internship at the Halifax Infirmary prior to going into private practice three years ago. He leaves to mourn his loss, his wife who is a pathologist at the Nova Scotia Hospital, and a daughter.

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The Nova Scotia Medical Bulletin extends sympathy to Doctor and Mrs. T. S. Laufer of Halifax on the death of her mother, Mrs. Herta Friedlander, which occurred on August 25th.

## ROLE OF CHLORPROMAZINE IN THE MANAGEMENT OF PSYCHIATRIC PATIENTS\*

Chlorpromazine reduces psychotic tension, restlessness and over-activity and calms the aggressive behaviour associated with acute and chronic psychotic disorders (Vaughan, Leiberman and Cook, 1955). Communication is improved and social rehabilitation follows, so that, in addition to an immediate and largely sedative response, psychotic patients may show a slow process of reintegration and improved social functioning which extends over many weeks before the maximum effect is seen. For this reason the drug should be continued for at least four to six weeks before deciding that it is not having the desired effect on the patient.

Patients who are a continual source of disturbance may become quiet, co-operative, occupied and able to leave hospital for short periods of leave. Their relatives find new interest in their welfare, and this is a further indirect help in their social recovery. With the most disturbing elements of a community treated in this way, a ward atmosphere may improve and other patients also become settled, socially improved and more responsive in the quieter environment.

The indications for prescribing chlorpromazine in psychiatry are generally similar to those for reserpine. Chlorpromazine is usually more effective more quickly and is less unpleasant for the patient. Reserpine acts more slowly over a longer period and, while the number of unpleasant side-effects is much greater than for chlorpromazine, there are none of the serious complications of chlorpromazine, such as jaundice and agranulocytosis. Rinaldi, Rudy and Himwich (1956) have studied the comparative action of reserpine, chlorpromazine and frenquel on chronic schizophrenia and claim that they are effective in that order. Reserpine and chlorpromazine are much more active than frenquel, with reserpine more effective for the catatonic and chlorpromazine more effective for the paranoid groups.

Individual responses are extremely variable and the dose must be determined for each patient. Dosage up to 2,000 mg. a day can be tolerated by adults, though at these levels Parkinsonian symptoms may develop. It is usual to begin with 75 mg. or 100 mg. or 100 mg. daily by mouth, gradually increasing the dose as necessary. There is probably no advantage in exceeding 600 mg. or 800 mg. daily.

For rapid action the intramuscular or intravenous routes should be used. The 2.5 per cent solution should be diluted about ten times with saline before being injected intravenously. Deep intramuscular injection is well tolerated, though it may occasionally cause pain at the site of the injection. The elixir of chlorpromazine (4 ml contains 25 mg.) is rapidly absorbed and in some instances is more effective than tablets.

Chlorpromazine can be combined with other physical treatments, such as insulin coma and E. C. T. For prolonged sleep, chlorpromazine may be combined with barbiturates, such as amytal and phenobarbitone, and antihistamines, such as phenergan, and in physically fit adults may be continued up to a month without difficulty.

Vaughan, G. F., Post-graduate Medical Journal. 33: 548:551, 1957.

\*From Medical Abstracts, December, 1957.