

# The Nova Scotia Medical Bulletin

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## Some Aspects of Nutritional Requirements In Pregnancy and Infancy

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It has been said that a woman's long term food habits prior to pregnancy, her diet early in pregnancy and her diet during the latter part of pregnancy all have important, although possibly different, effects on both the mother and the foetus.

Unquestionably there is some relationship between good nutrition and the outcome of pregnancy, but as to how much and to what extent is not truthfully known. Studies in Boston and Toronto have emphasized the importance of good nutrition in relation to a healthy normal offspring. However, other studies have failed to reproduce similar findings and have led to the belief that regardless of proper diet the infant will obtain satisfactory nutrition at the expense of the mother.

Wollam and Millen<sup>1</sup> in 1956 reported from animal experiments that a minimum requirement for vitamins must be provided or the resulting embryo will either die or be born congenitally deformed. Oldham et al<sup>2</sup> have stated that thiamine and riboflavin needs are not increased. This may be considered in the light of Warkany's animal experiments.<sup>3</sup> This investigator observed the effect of a riboflavin deficient diet in pregnant female rats. Skeletal defects occurred in the young but of particular interest was the observation that there existed a "critical period" of riboflavin lack that existed during the early days of pregnancy. If the pregnant rat was given riboflavin up to the 13th day of gestation skeletal deformities were prevented, but if given after the 14th day the young were not protected. It was felt that between the 13th day and the 14th day of gestation a critical period existed in which increased amounts of riboflavin were required for normal differentiation and development.

Nelson et al<sup>4</sup> produced multiple congenital abnormalities in the young of rats by a combination of dietary deprivation and feeding an antagonist of pteroylglutamic acid. If the deficient diet was instituted on the 10th day of gestation 100 per cent of the young were deformed. When instituted on the 11th, 12th and 13th day, 95, 65, and 30 per cent respectively were abnormal. This most interesting work would suggest that deficiency of, or an insufficient amount of a particular substance for a very short period of time during pregnancy may result in the young being born with some abnormality.

Malformations occurring early in pregnancy as a possible result of insufficient vitamin or food substances may be difficult to prevent, because the mother is occasionally not aware of the existence of pregnancy until after the second or third month of gestation. Vitamins and good nutrition are not prescribed frequently until after the middle or later part of pregnancy. If these substances are important in foetal formation then the only method of preventing abnormalities occurring in the foetus would be to encourage proper dietary habits in women before pregnancy, namely in adolescence and throughout their lives.

During the last month of pregnancy emphasis has been placed on the importance of protein and calcium in the diet, as the foetus gains 300 gm. of protein and 22 gm. of calcium during this last month of intra-uterine life.

Scientific evidence so far would only suggest an increased foetal need for

- (a) 400 I.U. Vitamin D during the last half of pregnancy
- (b) Vitamin A which would be met in the Vitamin D preparation.
- (c) Vitamin K requirement shortly before parturition.

Pregnancy has long been considered a time of nutritional stress for the mother. It is now felt that this stress may be much less than previously suggested as the metabolism of the pregnant woman is altered to allow nutrients to be readily absorbed and stored. This would be an explanation for the birth of normal infants to mothers who are obviously malnourished. Increased energy expenditure during pregnancy requires adequate caloric intake as metabolism may be increased as much as 20 per cent. However, extra calories may be harmful if obesity is present. Tomkins<sup>5</sup> has stated that "obese and underweight mothers have an increased risk of toxæmia."

It is necessary for the physician to be aware of a "false" weight gain in the pregnant patient—the increase in weight being due to excess water retention and not related to tissue excess. The restriction of calories in such a case could therefore be harmful.

In the pregnant mother calcium is absorbed more readily and is more efficiently stored. Protein is spared and nitrogen retention may be greater during pregnancy even if the protein intake is not increased. This is due to a decrease in breakdown of amino acids in the body so that protein is spared. The extra storage of protein and calcium is thought to be for lactation but may be also an emergency measure. An increased intake of these substances during the last trimester is therefore necessary.

Iron is more efficiently absorbed and stored during pregnancy probably related to the need of the infant. The anaemia present during pregnancy may occasionally be false because of the dilution effect produced by the abnormal retention of salt and water.

Iodine demands are increased but are generally met by the use of iodized salt. If salt is restricted iodine supplements should be used. Kemp<sup>6</sup> in 1939 reported that the number of stillbirths could be reduced by supplying ample iodine. The occurrence of endemic cretinism caused by maternal iodine deficiency is a well established entity.

Exaggerated claims have been made for various supplements to the diet during pregnancy. The indiscriminate use of multi-vitamins and multi-mineral preparations should be abolished as they are expensive to the patient and may possibly even be harmful. Most requirements can be met by education of the patient to ingest a normal diet of easily obtainable food.

In summary then the demands of the foetus and the pregnant mother may be met by<sup>7</sup>

1. Up to 500 more calories per day in the last half of pregnancy.
2. A daily increase of 25 grams protein and 1.5 grams calcium in the last trimester.
3. An iodine supplement if salt is restricted.
4. Some increase in Vitamin A.
5. 400 I.U. Vitamin D in the last half of pregnancy.
6. Administration of Vitamin B6 if there is severe nausea and vomiting to compensate for abnormal losses.
7. Administration of Vitamin K before parturition.

Infant feeding has been subject to whims and changes since the days of Hippocrates. Volumes have been written on the subject of breast feeding but in summary, as one well known physician has stated, "cows milk is for calves and breast milk is for humans." All the elements of proper and adequate nutrition are supplied in breast milk except Vitamin D and iron. Besides the nutritional value of breast feeding a distinguished Canadian pediatrician has added further advantages for using breast milk, namely (a) cats can't get at it, and (b) it comes in such cute containers.

It has been stated that there have been no basic changes in thinking about artificial feeding of infants in the last twenty years. The basic formula still consists of cow's milk, diluted with water, with sugar added to replace calories lost in dilution. Processing by heat, evaporation or acidification is considered to soften the curd and improve digestibility.

The only two vitamin supplements required by infants are Vitamin C and D. As evidenced by the recent reports in the Canadian Medical Journal in the past year scurvy still exists in Canada. An alarming increase was apparent from the report by Whelan et al<sup>8</sup> from the Toronto Sick Children's Hospital, who reported 86 cases from 1954 to 1956 inclusive. The Winnipeg Children's Hospital<sup>9</sup> reported 33 cases. All these 119 cases were fed evaporated milk formulae with 40 per cent of the Toronto cases also on prepared foods other than milk—evidence of the small amount of Vitamin C in some infant foods. Vitamin D intake should be limited to 800 I.U. per day to avoid over-dosage. Some cases of hypercalcaemia have been reported from England and Switzerland related to over administration of Vitamin D. Irritability, vomiting, constipation, failure to gain weight and mental slowing are all symptoms that may occur with Vitamin D over-dosage.

The early supplementation of feedings of fruits, meats, vegetables etc., which appears to be the modern trend are unnecessary, expensive and undesirable because of the possibility of promoting food sensitivity. Of particular interest is the supplement of iron. Iron deficiency anaemia in young infants is not uncommon in patients admitted to the Children's Hospital, Halifax. Lack of knowledge on the part of the parent regarding iron containing foods and poor guidance on the part of the family physician seems to contribute greatly to the prevalence of this condition.

Iron deficiency anaemia occurs when the supply of iron fails to meet the demand and is most frequently seen in the age group of eight months to two years.

It is frequently observed that milk and other foods of low iron content make up the diet of most anaemic infants. However, even a "good" diet in the quantities eaten by an infant may not provide sufficient iron if the needs are abnormally great or absorption is poor. Brokaw<sup>10</sup> failed to find the early introduction of cereal, vegetables and eggs had any significant effect on haemoglobin during the first year. Pure infant meats provide iron in moderate amounts but the mixtures of "meat and Farina" or similar combinations are negligible in the amount of iron provided to the infant. There is sufficient evidence available that although the physician should continue to recommend a "good" diet, he should not depend on it solely for the prevention and cure of iron deficiency anaemia in children.

The basic recommendations in the feeding of infants may be still enumerated<sup>7</sup>

1. Breast feeding is still recommended and is especially recommended for the low income groups.
2. The basic formula is still considered to be adequate, and very easily modified to suite individual needs.
3. Ascorbic acid and Vitamin D supplements are still recommended at an early age—and are the only vitamin supplements considered necessary and safe.
4. Thiamine and Iron are later needed and after the third month may be supplied in cereals, egg yolk and meats. Additional iron may be necessary in the form of a medicinal preparation.
5. True scientific evidence has not borne out some of the extravagant claims and recommendations for early supplementary feedings.

Today the public and the physician responsible for the care and feeding of young infants are subject to the overzealous claims of the food industries. Unfortunately, the claims of the less restrained element in the industry overcome the educational advertising of responsible firms. A lessening of requested information and guidance by parents from their physician instead, may be the result of the massive information now reaching parents from many other sources.

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# Prevention of Blindness In Canada: The Role of the General Physician

Based on an essay as part of the course in Preventive Medicine and presently published in the Dalhousie Medical Journal, Winter Issue 1959.

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The dark mantle of blindness has fallen on some 17,000 Canadians, at least another 5,000 have such poor sight that they could be classed as blind. Blindness is not a notifiable medical condition, therefore, the number of blind in Canada is not definitely known. However, from the records of the Canadian National Institute for the Blind, about one person in every eight hundred of the total population has poor enough vision to be considered blind.

The term, "blindness," implies total loss of sight. However, for practical purposes, blindness signifies loss of vision varying from complete absence of sight to an upper limit recorded as 20/200 in both eyes while wearing glasses (normal vision is recorded as 20/20). With 20/200 vision, a person can only read the same size test letter at a distance of 20 feet that a person with normal vision could read at 200 feet. With just 20/200 vision, one can see well enough to go walking in traffic, but ordinary newsprint cannot be read and the vision is not good enough to perform work requiring accurate vision. An additional small group are considered blind if their visual fields restricted to less than 10 degrees, even if their central vision is still good. Such persons see as if looking down a long tube. They cannot get around easily or safely and cannot do work requiring good vision.

The causes of blindness are many and may be summarized as follows:

Cataracts	25%
Congenital and Hereditary Conditions	15%
Infectious Diseases	15%
Glaucoma	12%
Myopia	9%
Injuries	7%
General Diseases	6%
Poisons	$\frac{1}{2}$ %
Cancer	$\frac{1}{2}$ %
Undetermined	10%
Total	100%

More than 40% of blindness resulting from disease could have been prevented by early diagnosis and treatment. Most of the injuries which have caused blindness were unnecessary and could have been prevented if proper care had been taken. Our aim is to discuss briefly the primary causes of blindness and what can be done by physicians to prevent blindness.

First, are those diseases which occur in infancy or early life which may give rise to loss of vision if left untreated, or if allowed to arise from controllable circumstances.

The first of these is gonococcal *ophthalmia neonatorum*. Ophthalmia neonatorum is defined as an ocular infection arising in the first twenty-one days of life, gonococcal being the most serious type. This condition has been brought dramatically under control in comparatively recent years, though the incidence was considerably reduced by the introduction of prophylactic measures towards the end of the last century. In 1876, this disease was responsible for 30% of the inhabitants of blind institutions in Europe; twenty years later, the figure had dropped to 19%, while today it reflects discredit upon all, if any infant is allowed to suffer visually from the results of this infection.

Prenatal hygiene can go a long way towards the prevention of gonococcal ophthalmia neonatorum. The classical prophylaxis consists of the instillation of 1% silver nitrate drops in each eye, and it is still considered by experts to be the most effective.

Of less importance is *retrolental fibroplasia*, a disease wherein the vitreous becomes filled or partly filled with a yellowish-white mass. The cause of this irrevocable loss of vision may be eliminated by **careful attention** to the oxygen concentration administered to the premature infant (never over 40% concentration, and for minimal time). Dr. Law states that in 1951 in England, 6,925 premature infants were born; 127 suffered from retrolental fibroplasia. Of these 6,925 babies, 800 who were born at home—therefore, not within reach of institutional oxygen therapy—included no case of retrolental fibroplasia. The importance of careful oxygen administration with respect to the prevention of this disease is obvious. In the past few years, the incidence of retrolental fibroplasia has dropped very considerably and today is not considered a major cause of blindness.

The next group of conditions is the **hereditary and familial group of diseases and dystrophies**, including those with a less well established but still undeniable hereditary or familial element. This group would include for example, myopia, glaucoma, optic atrophy, heredomacular degenerations, retinitis pigmentosa, and keratoconus.

**Myopia** is a well-known condition but there are many different kinds of myopia linked together only by the common factor of the refractive error; either as a static fact, or a progressive type of myopia which commonly goes on increasing in amount till puberty or after, and then becomes stationary, not bearing any pathological evils in its train. There is the progressive and "malignant" myopia, which commonly—though not always—progresses to a higher degree of refractive error than the previous kind. It is accompanied by degenerative haemorrhagic fundus changes of a relentless and devastating nature.

This list and discussion is by no means a complete one, for there are over forty eye disorders that have a hereditary element in their occurrence.

Congenital anomalies may result from a **maternal infection by rubella during the first trimester of pregnancy**. Termination of pregnancy in a case of maternal rubella infection is considered justified by some. Prenatal care and education occupies an important position with respect to the prevention of rubella infection in pregnancy. The necessity of prenatal care is clearly seen when we note the ocular congenital anomalies that may arise as a result of maternal rubella infection. These are cataract, microphthalmos, buphthalmos, and pigmentary fundus degeneration.

Most important in prevention of loss of vision in infancy and childhood is the early recognition of an eye likely to be used to a less extent than its

fellow eye. Nature appears to seize an opportunity for dereliction of visual duty, and often the result of disuse is loss of vision (amblyopia). Fortunately, vision can be regained if the condition is discovered in time. The phrase, "in time" cannot be exactly defined for there is considerable variation from patient to patient. The central nervous system patterns are usually established by the age of 3 to 4 years of age, so amblyopia of this type should be treated well before school age.

The most usual cause of this type of loss of vision is **strabismus**. It is clearly impossible for two eyes not in alignment to avoid giving rise to diplopia. This symptom is very rarely met within the child, who soon learns unconsciously to avoid it by suppressing—or, better, neglecting—the vision of the crooked eye. It is this avoidance of physiological function which gives rise to the loss of vision through disuse or, as it is called, amblyopia ex anopsia.

The first thing to be done, is a cycloplegic refraction (with drops), which can be carried out even in infants below one year of age. Often all that is required to correct the "strabismus", if the patient is far sighted, is the constant wearing of eye glasses during childhood years. If this is unsuccessful after two or three months then surgery to the extraocular muscles is usually done. In any case the secret of success is early treatment—"children do **not** grow out of it."

This means of prevention of loss of vision is important because of its frequency and its clinical obscurity—for the angle of strabismus may be very small and practically, or actually, undetectable by simple means. Regardless of the degree of strabismus, treatment is essential and any postponement of treatment could be quite disastrous.

Buphthalmia is a serious infantile disease which leads to loss of vision if untreated, and responds well to early treatment. Here **elevation of intra-ocular tension** is due to congenital malformation of the region of the globe responsible for the drainage of the aqueous humour. The inevitable result of the raised tension is expansion and enlargement of the globe; before this occurs, diagnosis is not possible by ordinary means of examination. It is unlikely that much damage is done in this stage but any suspicion of pathological enlargement of an infant's eye, should be the signal for immediate reference to an ophthalmologist, especially if this enlargement is accompanied by haziness of the cornea—however slight.

Proceeding chronologically, **glaucoma** is one of our gravest eye problems. At the present time, the disease is not preventable. If untreated, it leads to blindness. If treated in time, the vision can be saved for years of life. About two in every hundred persons over the age of forty have the disease, often unknown to themselves. Glaucoma has been so neglected that the disease accounts for 11% of all blindness. The main reason for this is that the common chronic form of glaucoma has no early presenting symptoms.

Glaucoma usually starts first in one eye and later involves the other. The disease occurs rarely in infancy and childhood, but becomes fairly common after the age of forty and reaches its highest incidence between the ages of fifty and seventy. In glaucoma, the aqueous drainage channels become partially closed and the fluid pressure in the eye rises. This pressure is communicated back through to the vitreous onto the retinal. The increased fluid pressure in glaucoma gradually destroys the retinal nerve cells, first, those which serve side or peripheral vision, and later, the cells which provide for frontal or central vision. Eventually, if untreated, glaucoma results in a hard painful, blind eye.



Broadly speaking, there are two types of primary adult glaucoma: acute (narrow angle) and chronic (wide angle).

**Acute glaucoma** is characterized by either mild or severe attacks. Mild attacks may only cause slight blurring of vision for hours or days, with or without eye pain, and the patient often does not consult a doctor. A severe attack will, or should, bring the patient to the doctor at once. There will be sudden loss of vision, with eye pain and inflammation and subjective visual disturbances, such as obscuration and haloes. Sometimes general illness, perhaps with vomiting, may be present. Immediate treatment within hours of onset is essential if vision is to be saved. Too often, such cases have been wrongly treated with disastrous results, often because an ophthalmologist was not consulted. It is now generally agreed that a drainage operation should be done in severe acute glaucoma after the eye tension has been lowered by medical means. The treatment of all types of glaucoma is directed towards lowering the abnormally high fluid pressure of the eyes. This is done by means of pilocarpine eye drops which open the aqueous drainage channels, assisted often by a carbonic anhydrase inhibitor which will slow up the formation of aqueous. In addition, operations may be done to open new drainage channels. In severe acute glaucoma, surgery, if successful, will keep the drainage channels open and will prevent future attacks.

Chronic simple glaucoma, which comprises 90 per cent of all glaucoma cases, is an insidious, sight-destroying disease. It is not the result of repeated acute attacks but is chronic from the start. For the most part, it may be asymptomatic and it, therefore, requires a very astute and alert practitioner to spot the early stages of chronic glaucoma, which if undetected may pursue a symptomless and relentless course towards loss of peripheral visual field and eventually to blindness itself. When symptoms are present, the patient may notice that his side vision is narrower than it once was. He may notice that it is more difficult to adjust his eyes to the dark and that coloured rings may be seen around lights at night. The eyes may seem tired and heavy. Eventually the central vision diminishes in spite of changes in glasses. Such symptoms do not necessarily mean that glaucoma is present but they indicate that some eye trouble has developed which requires an ophthalmologist's attention.

Fundusoscopic examination may confirm your suspicions by revealing early pathological cupping of the disc; examination of the visual field may reveal a loss of part of the field. Tonometry affords another method of investigation. It is a simple test which causes the patient little or no inconvenience and takes no more than two minutes to perform. Many authorities feel that routine tonometry is the best method of detecting glaucoma and it is believed that general practitioners should learn to perform this simple test and include it in every physical examination of patients over the age of forty. It is urged that medical schools should make sure that all undergraduates receive adequate instruction in the performance of tonometry as a public health measure.

In chronic glaucoma the mainstay of treatment is the daily use of pilocarpine eye drops which must be continued for life. In some cases, a drainage operation is performed if the eye drops do not control the disease. It is also necessary to note that belladonna, atropine and other mydriatics should not be prescribed without consultation with the ophthalmologist.

In concluding our discussion of glaucoma, there is much the general practitioner can do, particularly among his patients who are over forty years of age, that will lead to the detection of glaucoma much earlier than is now the case. Six points which have been recommended are:—

1. Ask the patient about occurrence of occasional blurring or clouding of vision, seeing rainbow effects around a distant light, one-sided headaches, discomfort in or around the eyes after excitement or worry or under reduced illumination. Inquire if the patient experiences difficulty in reading despite prescribed glasses.

2. Ask if there is a case of glaucoma in the family.

3. Measure the acuity of vision. Causes of lowered vision in one or both eyes should be investigated.

4. Note the size of the pupils and their reaction to light. Unequal or sluggish reaction to light should be investigated.

5. Examine each eye with the ophthalmoscope to see if the optic discs appear pale or cupped.

6. Check the ocular tension and test visual fields if tonometer or tangent screen are available. Digital palpation for tension and confrontation test for fields are crude and of value only in advanced cases.

In an effort to combat this great cause of blindness, the Blindness Control Division has assisted provincial authorities and ophthalmologists in setting up glaucoma clinics for needy patients. These clinics are financed by the National Health Grants Program and are located in Saint John, Quebec City, Montreal, Toronto, Ottawa, Winnipeg, Saskatoon, and Vancouver.

Some forms of **cataract**, another cause of loss of vision, may be prevented. The adequate treatment of such forms of intraocular inflammation as may give rise to complicated cataract will lessen the incidence; avoidance of trauma, and the provision of protective devices for workers in those occupations where damage to the eye from flying particles is likely, are further potent preventive measures.

The uncomplicated form of senile cataract is, however, a very common cause of loss of vision. While the condition itself is not preventable, the ensuing loss of vision is largely preventable, and if the general condition permits, these patients should be given the chance of vision by operation.

The **ravages of intraocular inflammation** may be lessened by judicious and timely measures which will lessen the severity and perhaps retard the recurrence of an attack and thus prevent loss of vision. The early diagnosis of iritis, and prompt treatment by mydriatics and steroids will go a long way towards this end.

Another problem arises when a patient complains of flickering in the peripheral field. This condition is easily missed by the physician. Nevertheless, this subjective symptom may herald an imminent **detachment of the retina**. Careful examination of the peripheral fundus under a mydriatic is a necessity since the operative prognosis is so very much better for a limited and early detachment than it is when the detachment is extensive and older.

**Trauma** also represents a major cause of blindness. Nevertheless, prevention may play a major role and thus reduce this as a major factor. With respect to children, eye injuries are very high. Parents of small children are urged to keep scissors, knitting needles, pencils, and other sharp objects out of reach. Hazards to older children's eyes are bows and arrows, darts, slingshots, and BB guns.

Even the simplest injury demands care, for the occasional one goes the wrong way, to the detriment of vision. Scrupulous care is necessary to protect the eye by means of antiseptic or antibiotic applications, and careful attention must be given in case the need develops for more active measures.

Suspected perforating injuries must be most carefully examined so that every measure can be taken to promote healing and also to prevent the onset of sympathetic ophthalmia. If intraocular haemorrhage has occurred, local and general rest are enforced, for absorption may be delayed or recurrence encouraged by activity, to the ultimate detriment of the visual prognosis.

A false picture may be presented by the eye which has suffered a non-penetrating injury as by a ball or blunt stock, for it may appear quite undamaged to external examination. Examination of the eye may reveal old oedematous, exudative and haemorrhagic changes indicating *commotio retinae*. The eye should be put at absolute rest so as to give it every opportunity for complete recovery, which will minimize the hazard of visual loss.

In reviewing briefly some of the causes of blindness, it becomes apparent that it is possible to prevent loss of sight, in part, by promoting early diagnosis and in part by eliminating the cause. To accomplish these objectives, general public education is essential. The role of the Canadian National Institute for the Blind is vital—its program includes briefly:

1. help to the indigent
2. promotion of eye research
3. educational activities
4. provision of preventive services, including case-finding and follow-up procedures.

The systemic diseases, such as diabetes mellitus and the cardio-vascular-renal group, have as one of their complications, especially in longstanding cases, eye defects resulting in eventual blindness. They should be found and treated early by all physicians.

In conclusion, everyone should give thought to the conservation of sight—their sight. They should bear in mind the importance of early and competent diagnosis. They must understand that they too, can go down into the shadows, unless they take care of their eyes, and unless, when vision appears to be affected, they seek the services of a physician.

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## Satan's Tool?

Bertha O. Archibald  
Pharmicist

There is not so much wonder about hypnotism in these days as there was some years ago.

One day one of the internes, Dannie Hoare, walked into the Dispensary of the old V.G. Hospital and remarked "Well, Dr. Kenny MacKenzie is going to hypnotize one of the patients in the O. R. today." "Dr. MacKenzie" I exclaimed, "You do not mean our Dr. MacKenzie." "Yes, of course, — why not?" "Well, I am surprised that a man of his calibre would stoop to such a thing. I think hypnotism is of the devil, and what is more, I do not believe that he can do it. A human being is a sacred thing, particularly one's mind." I might say that I had come to these conclusions through hearing that hypnotism was practised in various places of amusement as a means of entertainment. I had also known of a person who was hypnotized and placed in a store window in Halifax and was on exhibition there for some hours or days. All this seemed to me very wrong.

I heard later that the interne, in informing Dr. MacKenzie my views on hypnotism, had said that I did not believe that he could do it, and that I thought that he was possessed of the devil. Now that was hardly fair, but these internes must have their fun. . . . .

Later that morning I received a 'phone call from the Operating Room requesting my presence there. This was not unusual, as all the anaesthetics, drugs and instruments were issued to the O. R. from the Dispensary. So up I went, and was duly ushered into the theater. I noticed the patient lying on the table fully dressed, and learned later that she was a school teacher, and suffered from attacks of hysteria. The treatment for this condition was hypnotism, and Dr. MacKenzie had been treating her, being Chief of the Medical Service. While she was in a state of hypnosis he would impress on her the fact that in future she would not have such attacks.

The doctor finding her very susceptible to hypnotism had asked if she would mind being hypnotized for the benefit of the medical students for a demonstration, and she had willingly consented.

Around the table were all the medical students and the head O. R. nurse. The doctor held the end of his stethoscope in his hand and said to the patient "I want you to concentrate on this that I have in my hand. Now I am going to put you to sleep and when I say one, two, three I want you to waken immediately. You understand? She evidently did understand, for presently her eyelids closed and she appeared to be fast asleep. The doctor seemed to be concentrating deeply himself, it was clearly discernible that he was tense in every part. He then turned from his patient and walked over to me, and taking my arm escorted me to the far side of the table, and turning to the students said "Boys, this is Doubting Thomas." Then turning to the patient,— "Now— this is Miss A. . . . I want you to shake hands with her, and squeeze her hand good and hard." By this time I was trembling from head to foot, and gave her just the tips of my fingers, but how she squeezed them! It was as if they were held in a vice. When I had succeeded in pulling my hand away the doctor performed some simple demonstrations. He told the patient to hold out her arm and keep it straight and stiff, and turning to one of the students, said

"Try and bend her arm." First one tried, then another, but the arm seemed as if it would break before it would bend. "Make your body stiff as a board" said the doctor, and then two students raised the patient up and down three times, and her body did indeed remain stiff as a board.

The doctor now concentrated as he had when he put his patient under, and said in a commanding tone "one, two, three—wake up." She opened her eyes and the nurse took her back to the ward. He then gave a very interesting lecture, explaining how it was against the law to use hypnotism except for medicinal purposes, and that commercial hypnotizing was banned. He further explained that he had simply made the conscious mind dormant, and worked on the subconscious mind. That only a person of normal intelligence could be hypnotized, and that one could not go beyond the moral code of the subject without awakening her. I asked him "If you dropped dead while she was under your influence, what would happen? He replied that the patient would awaken in a few hours of her own volition. He also told of having told one patient while in a state of hypnotism "when you wake up go to the window and say 'Boys, it looks like rain today.'" The patient did so, and no doubt wondered why the students laughed.

Being not yet fully convinced of the authenticity of the experiment I went to the ward and talked with our recent patient. "Did you ever see me before?" I asked. "Yes, yes, you were in the operating room." "Now tell me—did you hear the doctor telling you to shake hands with me?" "No, I did not—I did not know anything until he wakened me. It was just as if I was asleep."

I was glad to learn that commercial hypnotism was banned, and my admiration for the doctor in the case was greatly enhanced, and I concluded that hypnotism was perhaps not, after all, one of Satan's tools.

## Bronchiectasis and Acute Pneumonia\*

William Ruberman, Irving Shauffer, and Thomas Biondo,  
The American Review of Tuberculosis and Pulmonary Diseases

**Introduction.** Bronchiectasis has been considered a disease that originates in childhood after a severe respiratory infection. During the past ten years, however, studies on young adults who recently had bouts of acute pneumonia suggested that adult infections might also be a cause of bronchiectasis. Studies of such "postpneumonic bronchiectasis" have indicated that in some instances the bronchogram naturally reverts to normal. The present study is concerned with the incidence, diagnostic features, and stability of bronchiectasis first discovered after recent pneumonic infections.

**Methods.** The clinical records and roentgenograms of 94 patients on whom bronchograms were performed over a 28 month period at the U.S. Army Hospital, Fort Dix, New Jersey, were reviewed. The first group consisted of 69 patients selected for bronchography from a total of 1,711 patients seen with acute pneumonia. The second group consisted of 25 patients whose history or chest roentgenograms suggested chronic bronchiectasis. Patient selection of bronchography was done on the basis of uniform criteria.

Bronchography was performed on the patients with pneumonia not less than one month after all clinical evidence of activity had subsided, and only after any residual roentgenographic abnormality was shown to be stable for at least three weeks. Repeat studies were made in 24 instances and each was performed at least eight weeks after the preceding one. All of the patients were bronchoscoped immediately prior to the first bronchogram.

Bronchiectasis was diagnosed only by the presence of obvious cylindrical or saccular dilatation of the bronchial lumen. No untoward reaction to the procedure was encountered except in patients with bronchial asthma. The latter all developed moderately severe wheezing that responded satisfactorily to standard therapy.

Bronchiectasis should be suspected when the roentgenogram of a patient with recent acute pneumonia shows very slow resolution of the pneumonic process and persistence of parenchymal rales and productive cough are noted.

**Results.** Of the 69 patients who recently had acute pneumonia, 29 were found to have bronchiectasis. One patient had an abnormal bronchogram that reverted to normal on the repeat study. Of the 18 patients who had not had an immediately preceding pneumonia, 5 had bronchiectasis and 13 were normal. Seven patients with asthma and chronic cough were studied. Six were found normal and one patient had an abnormal bronchogram.

The 29 patients with recent acute pneumonia who had bronchiectasis represent 1.7 per cent of the total number of patients with pneumonia seen during the same period. There was no significant difference in the past respiratory history of the bronchiectatic subjects compared with the group found to have normal bronchograms. There were significant differences, however, in the nature of the immediately preceding pneumonia in the two groups. In the bronchiectatic group the mean duration of roentgenographic evidence of pneumonia was two months, while it was one month in the normal group.

There was no significant difference between the two groups with respect to the extent of the pneumonic process as seen on the roentgenogram. A significantly greater proportion of patients in the group with bronchiectasis had prolonged fever and leukocytosis than of those in the nonbronchiectatic group, while there was no difference in the frequency of elevated cold and influenza hemagglutinin titers.

There was a significant difference between the two groups in the physical findings of the chest. While persistent parenchymal rales for one or more weeks following the subsidence of all acute manifestations of the pneumonia were noted in 75 per cent of the patients with bronchiectasis, this was true in only 11 per cent of the patients in the non bronchiectatic group. There appeared to be a similar increase in the frequency with which productive cough was present in the bronchiectate group.

In 20 patients, of the 29 studied, there was a direct correlation between the site of the bronchiectasis and the location of the preceding pneumonia.

Eighteen patients had bronchograms performed for indications other than those arising during the course of an acute pneumonia. All but three of this group were seen initially because of acute nonpneumonic respiratory infections (pharyngitis, bronchitis), and a suggestive respiratory history or abnormal chest roentgenogram. Five patients in this group were found to have bronchiectasis and 13 had normal bronchograms.

No differences were found in the two groups with regard to past history of pulmonary disease.

Seven patients with bronchial asthma were bronchographed because of the presence of bothersome, chronic productive coughs. Six of these had normal bronchograms. The seventh had an irregular dilatation of an intermediate bronchus.

**Discussion.** The results of this study indicate that bronchiectasis is a common pulmonary lesion and that its presence should be considered during the course of an acute pneumonia when certain clinical features are manifest. The most important of these features is a persistently abnormal chest roentgenogram, indicating incomplete resolution of the pneumonic process.

Parenchymal rales that persist longer than clinical signs of activity are of considerable importance. If, in addition to the above findings, the patient's pneumonia is characterized by prolonged fever, continued productive cough, and leukocytosis, the diagnosis of bronchiectasis is rendered more likely.

A bronchogram is warranted in every case. The procedure is easy to perform, carries no significant danger, and is the only objective method of demonstrating the presence and extent of the abnormality.

In the present series only one of 14 patients with bronchiectasis, in whom the examination was repeated, showed reversion of the process to a normal state.

Undoubtedly, persistent but reversible bronchial dilatation does occur after a pneumonia although the occurrence is not common. Furthermore, the presence of artefacts and the difficulties inherent in borderline diagnosis should caution against overstating the problem.

In the group of 18 patients bronchographed because of an abnormal respiratory history, 5 patients were found to have bronchiectasis. Specific history of rapidly repeated bouts of pneumonia, all of which cleared rapidly, was not found to be indicative of bronchiectasis. The roentgenographic finding of localized emphysema, segmental atelectasis, or honey-combing was

confined to the bronchiectatic group. A plain film of the chest, if it shows the positive findings noted above, is therefore of some value in the pre-bronchographic diagnosis of bronchiectasis. A normal chest roentgenogram in no way excludes the possibility of the presence of bronchiectasis.

The relationship of a preceding pneumonia to the bronchiectasis is uncertain. An underlying bronchiectasis could predispose to a more protracted course of pneumonia or, alternatively, a more severe pneumonic infection could so damage normal lung as to leave some permanent damage in the form of bronchiectasis.

It is believed that the available evidence does not warrant a definite conclusion on the subject. The mere association of two events does not denote a cause and effect relationship. The most that one can say is that the bronchiectasis first noted after a recent pneumonia may possibly, but not definitely, have been caused by the acute infection. Further proof will be necessary to establish this as a certainty.

\*Abstracted by National Tuberculosis Association.  
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**Reflections on Surgical Tuberculosis**, B. Blankoff, M.D., Brussels, Belgium. *Journal of International College of Surgeons*, 31: 98-103 (Jan.) 1959.

The author reports 98 operations (synovectomy and curettage), 11 of which were recently performed for tuberculosis of the bones and joints. These procedures included operations on 23 spines, 51 hips, 23 knees and 1 foot. He lists the results and describes in detail the complications encountered and the causes of failure when the result was unsatisfactory. He comments successively on the difficulties of diagnosis, the importance of anatomopathologic point of view, the indications for surgical intervention and their possible abuse, and the role of antibiotics in therapy. He points out the differences that exist between clinical and roentgenographic results, the duration of immobilization sclerous type of the disease and the type accompanied by persistent fever. The operation he describes is considered excellent for either children or adults when the onset of disease is recent, but distinctly bad for either in cases of long-standing tuberculosis. In any circumstances, it is a severe and demanding procedure which not every surgeon is competent to perform.



## Cystic Fibrosis of the Pancreas In Infants and Children

Physicians for many years have been seeing infants and children with chronic cough or respiratory infections, bulky foul stools and poor weight gain in spite of a good appetite. Some or all of these symptoms may occur in a child with cystic fibrosis of the pancreas. The incidence is said to be one out of every 600 live births and is much commoner than nephrosis, poliomyelitis, muscular dystrophy or leukemia. Generally one half of these children will die before five years of age. The diagnosis may be suspected when the child has any of the above symptoms and may be suggested by the absence of trypsin in the stools. Confirmation of the diagnosis however, is only made by the absence of trypsin in the duodenal juice following duodenal intubation. An interesting finding in these children is the presence of excessive amounts of sodium and chloride in the sweat, three to five times that present in a normal child. Shwachman has recently described a simple procedure that the physician may use in his office to assist in the diagnosis. A special Petri dish containing Agar with the addition of silver nitrate and potassium chromate may be used to indicate if the patient has excess chloride in the sweat. When the suspected child's hand, fingers or foot is pressed into the Agar a whitish yellow discolouration of the red Agar occurs if excessive chloride is present in the sweat. If a positive result is found then further investigation is indicated such as duodenal intubation for the presence or absence of trypsin.

At present there is no cure for this disease but patients have been described who are thirty or forty years of age. Generally however, most of the patients do not live past adolescence. Therapy consists of the daily administration of antibiotics to control the chest infection, the oral substitution of trypsin in the form of pancreatic extract and inhalation of special substances to thin out the viscid secretions that exist in the trachea and bronchi.

Recently the Children's Hospital, Halifax, inaugurated a special fibrocystic clinic to encourage the attendance of cases of known fibrocystic disease that exist in the province and generally in the Maritimes. This clinic will not only offer medical assistance to the patient but will also provide information and assistance to the practicing physician who may have some problem related to fibrocystic disease in his practice. It is hoped that through the function of this clinic further information will be obtained with regard to actual incidence of the disease in Nova Scotia and generally in the Maritimes. Special equipment, e.g. inhalation machines and special solutions etc., will be available for these patients. Research and investigation into this baffling disease has begun at the Children's Hospital and close contact will be made with other similar fibrocystic clinics in Canada and the United States. It is hoped that the family physician will find this clinic of assistance to him if any further information is required contact should be made to the Chairman, Fibrocystic Clinic, Halifax Children's Hospital, Halifax, N. S.

## Diphtheria Pertussis Polio Vaccine

The Department of Public Health wishes to announce that a supply of the quadruple vaccine, D.P.T. Polio is now on hand and will be made available to the physicians of the Province of Nova Scotia on the same basis on which triple toxoid has been made available in the past, i.e., physicians wishing to obtain this material from the Department of Public Health free of charge may do so by signing form C.D.C. 4 which states the material will be administered free of charge or at a reduced rate. As in the case of other biologicals, the D.P.T. Polio may be obtained from the Divisional Offices and, in the case of the City of Halifax, from the Commissioner of Health and Welfare.

The Department of Public Health obtains its D.P.T. Polio Vaccine from the Connaught Research Laboratories.

Diphtheria and Tetanus Toxoids Combined with Pertussis and Poliomyelitis Vaccines (DPT Polio Vaccine), as supplied by the Connaught Medical Research Laboratories is prepared as trivalent, formalin-inactivated poliomyelitis vaccine to which have been added purified and concentrated diphtheria and tetanus toxoids, and pertussis vaccine. Each c.c. contains in poliomyelitis vaccine approximately 40 Lf of diphtheria toxoid, 8 Lf of tetanus toxoid and 15 billion killed bacilli from strains in Phase 1, H. pertussis. The preparation is amber to cherry-red in colour due to the presence of a small amount of phenol-red indicator and is slightly turbid because of the pertussis component. It does not contain horse serum and therefore cannot induce sensitization to antitoxins. The final product contains not more than 0.5 units of penicillin, 200 megm. of streptomycin, and 10 units of polymixin B per c.c.

Diphtheria, whooping cough and poliomyelitis are diseases to which infants and children in the early years of life are susceptible. The death rates for diphtheria and whooping cough are highest among infants and children of pre-school age. Infection with poliomyelitis viruses are frequently acquired very early in life. It is obviously desirable that vaccination against these diseases be carried out as a routine procedure beginning at *three to six months of age*.

Tetanus is a common hazard of childhood. For this reason, tetanus toxoid has been included so that active immunity may be acquired against tetanus at the same time.

DPT Polio Vaccine, as distributed by the Laboratories in rubber-capped vials containing 10 c.c., contains as preservative benzethonium chloride in a concentration of 1:40,000.

### Dosage and Administration

DPT Polio Vaccine should be administered by subcutaneous injections. These injections may conveniently be made into subcutaneous tissue of the upper arm near the insertion of the deltoid muscle.

### For Infants and Children OVER Six Months of Age

For infants and children over six months of age, it is recommended that three subcutaneous doses of 1 c.c. be administered with an interval of one month between the first, second and third doses, and a reinforcing dose of 1 c.c. not less than six months after the third dose.

### Storage

DPT Polio Vaccine should preferably be kept at a temperature of 35-40°F. (2-5° C.). However, unopened containers may be kept for several days at temperatures up to 50°F. (10°C.).

### Caution

The vaccine should be amber to cherry-red in colour, and slightly turbid. Any vaccine that has turned yellow should not be used. NOTE—In each instance when a dose is to be withdrawn from a vial, the withdrawal of the dose should be made IMMEDIATELY FOLLOWING VIGOROUS SHAKING of the vial.

The Connaught Medical Research Laboratories have informed us that they are preparing a second new antigen, D.T. Polio. This second new antigen will be for use in older children and adults who do not require pertussis vaccine. It is expected that D. T. Polio will be available in a few months.

### Reactions

It has been reported on rare occasions that convulsions, sometimes followed by neurological complications, have resulted from the injection of pertussis vaccine. It is recommended that pertussis vaccine alone, or in combination with other antigens NOT be given to infants or children with fever or other evidence of acute illness, or with a history of convulsions, and that in all instances the series of inoculations be discontinued if a very severe reaction or convulsions occur as the result of a first or subsequent dose. It might be advisable to proceed with caution in cases with evidence of cerebral damage of other types, and in those who have shown previous evidence of hypersensitive reactions. It is always possible that an individual highly sensitive to penicillin or streptomycin may be encountered. It is desirable, as in the administration of all vaccines, to have epinephrine hydrochloride solution (1:1000) available as a safeguard.

**INFECTIOUS DISEASES—NOVA SCOTIA**  
**Reported Summary for the Month of January, 1959**

Diseases	NOVA SCOTIA				CANADA	
	1959		1958		1959	1958
	C	D	C	D	C	C
Brucellosis (Undulant fever) (044)	0	0	0	0	0	8
Diarrhoea of newborn, epidemic (764)			0	0	0	0
Diphtheria (055)	0	0	0	0	5	7
Dysentery:						
(a) Amoebic (046)	0	0	0	0	0	0
(b) Bacillary (045)	0	0	0	0	0	0
(c) Unspecified (048)	0	0	0	0	0	0
Encephalitis, infectious (082.0)	0	0	0	0	0	0
Food Poisoning:						
(a) Staphylococcus intoxication (049.0)	0	0	0	0	0	0
(b) Salmonella infections (042.1)	0	0	0	0	0	0
(c) Unspecified (049.2)	0	0	0	0	0	0
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	73	0	1	0	0	0
Meningitis, viral or aseptic (080.2, 082.1)						
(a) due to polio virus	0	0	0	0	0	0
(b) due to Coxsackie virus	0	0	0	0	0	0
(c) due to ECHO virus	0	0	0	0	0	0
(d) other and unspecified	0	0	0	0	1	2
Meningococcal infections (057)	0	0	0	0	0	43
Pemphigus neonatorum (impetigo of the newborn) (766)	0	0	0	0	0	0
Pertussis (Whooping Cough) (056)	6	0	80	2	515	815
Poliomyelitis, paralytic (080.0, 080.1)	0	0	0	0	3	3
Scarlet Fever & Streptococcal Sore Throat (050, 051)	193	1	601	0	1743	1508
Tuberculosis						
(a) Pulmonary (001, 002)	**	1	22	0	51	847
(b) Other and unspecified (003-019)		0	1	0	19	56
Typhoid and Paratyphoid Fever (040, 041)	3	0	0	0	5	24
Venereal diseases						
(a) Gonorrhoea —						
Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	26	0	33	0	995	1506
(b) Syphilis —						
Acquired—ordinary (021.0, 021.1)	1	0	1	0	0	12
— secondary (021.2, 021.3)	0	0	0	0	0	3
— latent (028)	3	0	0	0	0	0
— tertiary — cardiovascular (023)	1	0	0	0	0	0
— „ — neurosyphilis (024, 026)	0	0	0	0	0	0
— „ — other (027)	1	0	2	0	0	0
Prenatal—congenital (020)	1	0	1	0	0	0
Other and unspecified (029)	0	0	3	3	151*	172*
(c) Chancroid (036)	0	0	0	0	0	0
(d) Granuloma inguinale (038)	0	0	0	0	0	0
(e) Lymphogranuloma venereum (037)	0	0	0	0	0	0
Rare Diseases:						
Anthrax (062)	0	0	0	0	0	0
Botulism (049.1)	0	0	0	0	0	0
Cholera (043)	0	0	0	0	0	0
Leprosy (060)	0	0	0	0	0	0
Malaria (110-117)	0	0	0	0	0	0
Plague (058)	0	0	0	0	0	0
Psittacosis & ornithosis (096.2)	0	0	0	0	0	0
Rabies in Man (094)	0	0	0	0	0	0
Relapsing fever, louse-borne (071.0)	0	0	0	0	0	0
Rickettsial infections:						
(a) Typhus, louse-borne (100)	0	0	0	0	0	0
(b) Rocky Mountain spotted fever (104 part)	0	0	0	0	0	0
(c) Q-Fever (108 part)	0	0	0	0	0	0
(d) Other & unspecified (101-108)	0	0	0	0	0	0
Smallpox (084)	0	0	0	0	0	0
Tetanus (061)	0	0	0	0	0	0
Trichinosis (128)	0	0	0	0	0	0
Tularaemia (059)	0	0	0	0	0	0
Yellow Fever (091)	0	0	0	0	0	0

C — Cases D — Deaths

\*Not broken down.

\*\*Figures for tuberculosis for January 1959, not yet available.

# Resume Minutes of Executive Committee Meeting

January 26 1959

The morning session of this meeting was held in the Board Room of the Dalhousie Public Health Clinic. The Chairman called the meeting to order at 9.30 a.m.

Present were:

H. J. Devereux, M.D.	—	President
W. A. Hewat, M.D.	—	President Elect
A. L. Murphy, M.D.	—	Past President
A. W. Titus, M.D.	—	Treasurer
D. I. Rice, M.D.	—	Executive Chairman
J. A. MacCormick, M.D.	—	Antigonish-Guysborough Medical Society
L. S. Allen, M.D.	—	Cape Breton Medical Society
H. J. Martin, M.D.	—	Cape Breton Medical Society
D. R. Davies, M.B.	—	Cumberland Medical Society
F. A. Dunsworth, M.D.	—	Halifax Medical Society
A. M. Marshall, M.D.	—	Halifax Medical Society
*J. W. Merritt, M.D.	—	Halifax Medical Society.
R. G. A. Wood, M.D.	—	Lunenburg-Queens Medical Society
F. J. Granville, M.D.	—	Pictou County Medical Society
J. P. McGrath, M.D.	—	Valley Medical Society
D. R. Campbell, M.D.	—	Western Nova Scotia Medical Society
H. C. Still, M.B.	—	Editor-in-chief, N. S. Medical Bulletin
R. O. Jones, M.D.	—	Representative N. S. Division to Executive C.M.A.
C. J. W. Beckwith, M.D.	—	Secretary

No representative was present from the Colchester-East Hants Society.

\*A. J. R. Brady, M.B., alternate for Dr. Merritt, attended afternoon and evening sessions.

The Chairman after welcoming the members stated that it was necessary to spend considerable time reviewing the position of the Society in relation to insured medical services under the Hospital Insurance plan. He expressed his desire to cover as much of the agenda as possible during the morning session so as to devote as much time as necessary in the afternoon to this subject.

**The Minutes of the Regular Meeting of the Executive**, held October 23, 1958, had been distributed to members of the Executive and a resume printed in the Bulletin.

Moved by Dr. F. A. Dunsworth, seconded by Dr. R. G. A. Wood, "That the Minutes be adopted as distributed." Carried.

### **Business Arising from Minutes of Meeting of October 23, 1958.**

The Chairman informed the meeting that this business was in the form of reports and would be dealt with later in the Agenda.

**The Minutes of the First Meeting of the New Executive**, held October 25, 1958, had been distributed to members of the Executive and a resume printed in the Bulletin.

Moved by Dr. R. G. A. Wood, seconded by Dr. F. J. Granville, "That the minutes be adopted as distributed." Carried.

#### **Business Arising from Minutes of Meeting of October 25, 1958.**

#### **Selection of Chairman for Standing Committee on Civil Disaster.**

The Chairman reported that the physician who had been requested to take this Chairmanship had not found it possible to do so. Dr. J. W. Merritt was elected Chairman of this Committee.

#### **Proposed Resolutions Committee**

This subject had been introduced at the first meeting of the New Executive Committee but it had not been finalized. The Chairman explained that its function, in general, would be that each resolution emanating from Branch Societies, affiliated societies and members would receive attention and study by a committee of the Executive.

Discussion resulted in the following resolution:

Moved by Dr. J. P. McGrath, seconded by Dr. W. A. Hewat—"A Resolution Committee be appointed which would receive Resolutions as submitted by organizations within the Society. Receipt of Resolutions to be promptly acknowledged. The context or wording of the same, not to be changed without the permission of the mover or seconder of that Resolution. The Resolutions Committee is to present the same to the next meeting of the Executive of The Medical Society of Nova Scotia for their consideration and subsequent presentation to the next meeting of The Medical Society of Nova Scotia."

On a show of hands, there were six votes for this motion and six against. The Chairman gave the deciding vote by voting for the motion. Motion Carried.

#### **Present Status of Standing Committees.**

The Secretary reported that only nine of the fifteen Chairmen appointed at the Annual Meeting, 1958, had submitted the names of members of their Committees.

Discussion resulted in the following resolution:

Moved by Dr. A. W. Titus, seconded by Dr. H. J. Martin, "That in naming chairmen of standing committees in future the procedure will be as follows:

1. A letter naming him as chairman be sent out by the executive secretary asking if he will accept and that he be requested to reply by letter, his acceptance or refusal.
2. That if no reply is received by the Executive Secretary within one month that the secretary be empowered to follow up this acceptance or refusal by telephone or other means, at his discretion.
3. A person accepting chairmanship of a standing committee assumes the responsibility of naming his own committee." Carried.

**Minutes of Meeting of "Nucleus" of Executive Committee**, December 15, 1958, had been circulated to members of the Executive.

Moved by Dr. H. J. Martin, seconded by Dr. H. J. Devereux, "That the Minutes be adopted as printed." Carried.

**Review of Principle of a Nucleus Committee.** The opinion had been expressed by the Chairman of the Executive Committee at its First Meeting, 1958, that occasions arise when decisions are to be made and opinions from more than one or two needed but not necessarily full Executive Committee. At that time, authority had been granted for the Secretary and the Chairman to seek advice from members of the Executive Committee in the Halifax area when such occasions arise. It was on this authority that the meeting of December 15th had been called. During that meeting the opinions of the members present had been asked as to whether they considered that a meeting of the Executive should be called or whether under the existing circumstances a telephone conversation with each members would accomplish the objective. The advice had been to contact the members by telephone. The Chairman asked if there were any questions regarding this.

A member stated that according to the By-Laws, the authority of The Medical Society of Nova Scotia is given to the Executive Committee to conduct the business of the Society between Annual Meetings. When wishing a decision, the Executive should meet as a whole or a "mail ballot" be obtained as outlined in the Constitution. For the members in the Halifax area to have a meeting and then contact the remaining members by telephone, for those members to give a decision over the telephone, is not legal and does not give the members contacted by telephone any time to think about the matter. It would be difficult to justify such procedure to the Branch Societies. This individual instance is not necessarily a point of contention but the general application of the principle involved is under examination. Another member expressed the opinion that the idea of a Nucleus Committee was not good unless made up of representatives from each Branch. The Chairman stated that all Standing Committees have Nucleus Committees, it is almost necessary for the Executive Committee. In point of practice, day by day decisions have to be made which cannot wait for meeting of the entire Executive. In past, decisions have been made by Secretary and Chairman and one or two members in vicinity. The matters under review at the meeting of December 15th required immediate decision and it was not possible to convene a meeting of the complete Executive because of their urgency. It is highly desirable that some decision be made as to how such urgent matters would be dealt with in the future. If full Executive is to be called, then it must be done. If there is some other method, what is it? Is it important enough to change By-Laws to make such a committee as a Nucleus Committee legal? It was questioned whether it is asking too much for the Society to be requested to make a forty-eight-hour decision. A member suggested if decision too large for Chairman and Secretary, they should be given authority to obtain opinions from Halifax area as has been done previously, without definite Nucleus Committee. Another member felt that as the practice of medicine in Nova Scotia is quite diversified, some urban and some in smaller centres, there will be different views which should be obtained. The Chairman doubted whether it would be possible for the members in outlying areas to convene within forty-eight hours. It was wondered just how often such quick decisions would be necessary. It was agreed that it might be only very occasionally but that there should be a recognized procedure if and when the occasion arises. The Chairman stated that in future, decisions which affect the Society will be made by the complete Executive and there is no need to change any By-Law to authorize a Nucleus Committee.

**NEW BUSINESS**

The following nominations for the Canadian Medical Association were made.

1. For Senior Membership C.M.A. — Dr. J. C. Ballem, New Glasgow.
2. To C.M.A. Nominating Committee, 1959 — Dr. A. L. Murphy.
3. To C.M.A. Executive Committee, 1959-1960 — Dr. R. O. Jones (Second Year).  
Alternate to C.M.A. Executive Committee, 1959-1960 — Dr. H. J. Devereux.
4. To Trusteeship Committee C.M.A., 1959-1960 — Dr. A. W. Titus.  
Alternate Representative to Trusteeship Committee C.M.A., 1959-1960 — Dr. C. H. Young.
5. Official Representative to C.M.A. — B.M.A. Meeting, Edinburgh, 1959 — Dr. W. A. Hewat.

**Remarks Relative to General Council C.M.A. (May 29-30, 1959).**

The Secretary informed the meeting that the General Council C.M.A. would meet in Toronto in conjunction with the Annual Meeting of the Ontario Medical Association. The Nova Scotia Division is entitled to nine representatives, five of whom are fixed and four selected by the Chairman, President and Secretary.

Moved by Dr. F. J. Granville, seconded by Dr. R. G. A. Wood, "The Policy of the past be followed in choice of four representatives." Carried.

Authorization was given for the purchase of a suitable Nova Scotia flag and staff for presentation to C.M.A. House.

**Property Committee**

The Secretary stated that there are now reasons for such a Committee, or to allocate such duties to a presently standing Committee. The Executive directed that the Finance Committee be requested to assume these duties.

**Membership Committee**

The roll of this Committee has been advisory. The Secretary requested authority to have this Committee assume a more active role in increasing membership. This was agreed.

**Proposed Change in Vital Statistics Act.** Dr. J. S. Robertson, Deputy Minister of Public Health, stated he was present in the capacity of Deputy Registrar General. He said that for quite some years considerable argument had taken place over definition of "live birth" and "still birth." The World Health Organization wished to have these standardized. If anything is to be presented for legislation, it must be given prompt attention as the House opens soon. (February 4, 1959). Presently, in Nova Scotia, if the birth of a fetus after being separated from mother shows any sign of life, it is a live birth. However, it is sometimes difficult to ascertain what is sign of life. Hospital medical staffs are confused on this matter, different staffs have different ideas of what is a definite sign of life. Signs of life can be heart beat, breathing, pulsation of umbilical cord, definite movement of a part. The latter, "definite movement of a part" can be rather indefinite. It is desirable that a standard definition be arrived at as to what is a "live birth." Also, there is some misunderstanding regarding the disposal of fetus. There is no difficulty disposing



of a still birth. However, if a living birth, some feel that it must be registered and buried. This is not necessarily so, according to legislation. The World Health Organization and several provinces have agreed to this new proposal of Definition of Live Birth and Still Birth. Dr. Robertson said he would like the opinion of the medical profession of Nova Scotia and whether this proposal is workable.

Moved by Dr. A. M. Marshall, seconded by Dr. D. R. Campbell, "that the Executive of the Nova Scotia Branch of the C.M.A. agree in principle with the proposed changes in the Vital Statistics Act as outlined by Dr. Robertson, Deputy Registrar of Vital Statistics, to bring our Vital Statistics in line with those proposed by the World Health Organization." Carried.

The meeting adjourned at 12.30 for luncheon at the Lord Nelson Hotel.

The afternoon session was convened at 2.15 p.m. with the Chairman, Dr. D. I. Rice, in the chair.

### Reports of Committees

**Committee on Medical Economics**—Welfare Group Agreement between the Government of Nova Scotia and The Medical Society of Nova Scotia. The Executive was given the background of this matter including a summary of the Committee's meeting with the Minister of Public Welfare on September 3rd. At the Executive meeting in October, word from the Minister was to the effect that the request for \$1.27 per recipient was under review. A letter received January 26th stated in part that "An increase in the rate from \$1.00 to \$1.10 per month has been approved by Government."

After thorough debate, the following resolution was presented:

Moved by Dr. H. J. Devereux, seconded by Dr. F. A. Dunsworth, "That the Executive of the N. S. Medical Society find your offered increase of Ten Cents unacceptable and wish to negotiate with you in the immediate future." Carried.

The Committee on Medical Economics was authorized to continue negotiations. (A meeting with the Minister of Public Welfare was arranged for February 24, 1959).

### Advisory Committee on Health Insurance

Dr. Rice welcomed Dr. D. M. MacRae (Chairman) and the following who had been invited to attend as observers:

Dr. C. B. Stewart	} Members, Advisory Committee on Health Insurance
Dr. H. E. Christie	
Dr. H. R. Roby, President, N.S.A.R.	
Dr. R. H. James, Secretary-Treasurer, N.S.A.R.	
Dr. W. A. Taylor, President, N.S.A.P.	
Dr. J. N. Park, Secretary-Treasurer, N.S.A.P.	

The Chairman requested Dr. MacRae to present the report of the Advisory Committee on Health Insurance.

Dr. MacRae presented a review of the activities of his Committee since the time of the Annual Meeting, 1958, relative to the provisions of insured medical services under the Nova Scotia Hospital Insurance Plan.

Moved by Dr. J. W. Merritt, seconded by Dr. R. G. A. Wood, "That this Report be adopted."

**Discussion:**

Dr. MacRae requested a review relative to **uninsured diagnostic services**. The Commission had agreed it "would refrain from setting the rates to be charged for uninsured out-patient services." The question arose as to uninsured in-patient diagnostic services—in principle it would appear that these should not be dealt with by the Hospital Insurance Commission. His Committee wished to have direction from the Executive. After extended debate, the following resolution was adopted:

Moved by Dr. W. A. Hewat, seconded by Dr. D. R. Campbell, "Uninsured in-patient medical services should not come directly under the N. S. Hospital Insurance Commission and that our Advisory Committee be instructed to discuss this matter with the Commission." Carried.

The relationship between The Medical Society and the Hospital Insurance Commission was closely examined. It was recognized that Medicine had enjoyed close liaison from the very beginning of the formation of the Hospitalization Plan by (1) representation in the Hospital Planning Committee, (2) representation on the Advisory Committee to the Hospital Services Planning Commission, (3) a practising member of the profession on the Hospital Insurance Commission and (4) more recently in the formation of the Professional and Technical Advisory Committee. Our Advisory Committee on Health Insurance had expressed the views and recommendations of Medicine to each of these bodies and they in turn had asked for and received advice on matters brought to the attention of our committee. With the Plan in operation as of January 1, 1959, the Hospital Insurance Commission had many groups to deal with and many problems to solve. It is doubtful whether "negotiation" in the strict sense of the term is recognized. However, there is no doubt that Medicine has and will continue to influence the Commission by expressing considered views and advice on problems.

It was emphasized that the Commission viewed the Hospital as the unit with which agreements had to be made. This is regarded by Medicine as advisable, however the present difficulties which Medicine is encountering results from the fact that Hospitals have not received from the Commission the essential information on which an agreement can be concluded between the Hospital and the physician for the provision of medical services identified as insured.

This brought into the debate the present difficulties in relationship to the remuneration, and more particularly the method followed in arriving at the remuneration, for insured professional services rendered by pathologists and radiologists. It was stated that a minority of the radiologists and none of the pathologists had been approached by their hospital nor had they had the opportunity to assist in preparing the budget for professional services. The information given by the Commission to the Hospitals on December 31, 1959 had been either inadequate or misinterpreted. Inquiry indicated that the "interim" budgets to hospitals, which presented in fact the monies made available for these services, had not been distributed to Hospitals, that each would be discussed with the Hospital concerned after which the budget would become a "provisional budget" and still open for adjustment in the light of actual experience. The budget for insured professional services submitted to the Commission by a hospital had been examined and several factors applied from which the amount had been agreed to or changed in the interim budget.

As of this date, these amounts are not known. However, Medicine is primarily interested in the principles on which remuneration is to be based and had presented a plan in September to the Advisory Committee of the Hospitals and the Hospital Insurance Commission. These principles were reviewed and it was believed that the sole objection lay in the results of the application of the proposed formula for remuneration based on an optimum "work-load." Indeed the results represented three viewpoints, those of the Commission, the Hospitals and Medicine, each based on information available from past experience and each attempting to estimate the future. Now that the plan is in operation, actual case loads will be known. The representatives of both pathologists and radiologists expressed views about the subject and both agreed to follow the policies as approved by the Society.

The following resolution was presented:

Moved by Dr. J. W. Merritt, seconded by Dr. F. A. Dunsworth, "That the remuneration of medical personnel rendering service to patients in hospitals covered by the Nova Scotia Hospital Insurance Commission shall be negotiated between such medical personnel and the hospitals using the method of remuneration of The Medical Society of Nova Scotia as a basis of negotiation. If agreement cannot be reached, then the matter should be negotiated between the Nova Scotia Hospital Insurance Commission and The Medical Society of Nova Scotia." Carried.

The Chairman of the Executive asked for views as to the position the radiologists and pathologists would take during the ensuing discussions. It was agreed that no final arrangement would be concluded with hospitals until discussions resulted in a satisfactory agreement; that professional services would continue with remuneration being accepted on an interim basis only; that the contracts forwarded to hospitals would be used as a basis for discussion for the time being and that the present situation will continue to be under active study by the Committee.

Doctors Taylor and Roby both expressed appreciation for the invitation from the Executive Committee to be present and for the information which had been obtained during the discussion.

The recommendations included in this report were considered, namely:

1. That this Committee arrange a meeting with the Hospital Insurance Commission.
2. That Radiologists and Pathologists continue to provide medical services pending clarification of the issues involved.
3. That the Executive Committee appoint a special committee with representation from the Radiologists and Pathologists and this committee be directed to apply the recommendations of The Medical Society of Nova Scotia to actual work-loads.
4. The Radiologists and Pathologists adhere strictly to their optimum workloads and make bookings as necessary.

In reference to the request for a special committee to study work-loads and remuneration for insured services, the following resolution was presented:

Moved by Dr. F. A. Dunsworth, seconded by Dr. H. J. Devereux, "The Executive Chairman and the Chairman of the Advisory Committee on Health Insurance be empowered to meet with representatives of the Radiologists and Pathologists and then to appoint a representative committee to apply the recommendations of The Medical Society of Nova Scotia concerning work-loads." Carried.

The motion for adoption of report of the Advisory Committee on Health Insurance was presented and carried.

### **Application from Nova Scotia Association of Pathologists for Recognition**

A request had been received from the Nova Scotia Association of Pathologists for recognition from The Medical Society of Nova Scotia as an affiliated Society.

Moved by Dr. A. W. Titus, seconded by Dr. A. L. Murphy, "That the Nova Scotia Society recognize the Nova Scotia Association of Pathologists as an affiliated Society." Carried.

The meeting was **adjourned at 5.45 p.m.** to reconvene at 7.30 p.m.

The meeting was **reconvened by the Chairman at 7.40 p.m.**

## **REPORTS**

### **Committee on Legislation**

In the absence of Dr. J. McD. Corston, Chairman of the Committee on Legislation, Dr. Titus was requested to present the report, as follows:

"The Nucleus Committee has been enlarged by three new members in the persons of Dr. J. P. McGrath, Kentville, and Drs. J. O. Godden and A. W. Titus, Halifax. This Nucleus Committee has been working in close liaison with the Provincial Medical Board through the Registrar, Dr. M. R. Macdonald and also in two formal meetings with the Legislative Committee of the Provincial Medical Board.

At the most recent meeting of the two Committees held on January 12, 1959, certain proposed amendments to the Medical Act, which we had drawn up in consultation with our solicitor, were brought to the attention of the Legislative Committee of the Provincial Medical Board. These proposed amendments were fully discussed and agreement was reached as to their importance and worth.

The Provincial Medical Board brought to our attention proposed amendments to Chapter 172 R.S.N.S. 1954 the Medical Act, having to do with the formation of a Discipline Committee of the Medical Board and outlining the duties and responsibilities of said Committee. Your Legislative Committee concurs with the Medical Board in this matter.

As the Executive Secretary has copies of the Draft Amendments, above-mentioned, on file, I feel that detailed descriptions would be superfluous in this report.

### **Re Barbiturates and Tranquillizers**

The Council of the Nova Scotia Pharmaceutical Society, with which your Committee has been making a joint approach to control of the problem, met in November and considered our joint recommendations. Following this, a further meeting was held, after which the following letters were sent:

Letter to Mayor Vaughan and enclosed similar letters addressed to:

Hon. R. A. Donahoe, Attorney General of Nova Scotia

Hon. R. A. Donahoe, Minister of Public Health

Hon. J. W. Montieth, Minister of National Health and Welfare

Mr. R. J. McCleave, M.P.

Mr. Edmund Morris, M.P.

Dr. A. R. Morton, Commissioner of Health

A covering letter to Mayor Vaughan.

(These communications have been forwarded to these gentlemen with covering letters over the signature of Mayor Vaughan).

Two letters were sent to Dr. A. D. Kelly, General Secretary C.M.A., with a request that one be forwarded to the appropriate C.M.A. Committee."

Moved by Dr. A. W. Titus, seconded by Dr. R. G. A. Wood, "That the report of the Committee on Legislation be adopted."

Dr. Titus answered some questions from the members following which the motion for adoption was put and carried.

### Budget Committee

This report was presented by the Treasurer, Dr. A. W. Titus, who stated that it had been drawn up in consultation with the Committee on Finance.

The following is the estimated budget of The Medical Society of Nova Scotia for the year 1959, with the actual comparative figures for 1958.

### INCOME

	1958	1959
Membership dues (Medical Society & C.M.A.)...	\$ 34,393.00	\$ 36,000.00
Medical Bulletin.....	1,314.76	1,300.00
Convention receipts.....	656.55	1,500.00
Grant—C.M.A.....	1,010.00	1,050.00
Investment income.....	1,050.37	1,100.00
Post-graduate levy.....	2,810.00	3,000.00
Rolph, Clark, Stone—contra account.....	181.75	180.00
Subscriptions to Bulletin.....	32.50	40.00
Schedule of Fees.....	118.00	50.00
	<hr/>	<hr/>
	\$ 41,566.93	\$ 44,220.00

### EXPENSES

Canadian Medical Association (Membership dues)...	9,813.00	10,000.00
Salaries.....	13,739.98	16,300.00
Travel.....	2,673.77	2,600.00
Postage.....	232.73	250.00
Bank charges.....	76.52	75.00
Telephone and Telegraph.....	420.87	450.00
Office supplies and stationery.....	1,054.70	1,100.00
Legal, audit and accounting.....	960.00	1,000.00
Contributions to pension plan.....	1,496.40	1,400.00
Sundries and expenses.....	376.03	475.00
Post-graduate committee.....	3,725.00	3,900.00
Depreciation.....	576.65	600.00
Schedule of fees.....	1,285.63	100.00
Luncheons and meetings.....	596.15	400.00
Additions and alterations to office.....	487.93	100.00
Unemployment insurance.....	27.12	60.00
	<hr/>	<hr/>
	\$ 37,542.48	\$ 38,810.00

It will be noted that while our expenses remain at approximately the same level as last year, we are budgeting for an increase of approximately \$2,200.00 in income.

Moved by Dr. A. W. Titus, seconded by Dr. A. M. Marshall, "That the report of the Budget Committee be adopted.

Questions were asked on several items, all of which were answered. The motion for adoption was presented and carried.

### Special Committee on "Job Evaluation"

The Chairman, Dr. F. A. Dunsworth, gave an interim report which resulted from four meetings of his Committee. The report included the following:

"We believe that it has to be recognized that any employer has the right to examine the basis of employment of his employees. We feel, however, that the method used in examining professional positions should be open to constructive criticism and on this basis your Committee recommends the following resolutions:

1. Any evaluation of physicians and surgeons should be performed by physicians and surgeons competent to evaluate the work of different branches of Medicine; the principle of non-professional people evaluating professional staff be not accepted.
2. If a professional job evaluation is to be attempted, the forms as presented by J. Barnum Associates to the members in the Provincial Service are not suitable to evaluate professional work.
3. We request that in any evaluation of physicians and surgeons in Civil Service the benefit and experience of this Society be sought.

We would recommend that these resolutions, if accepted by Executive, be brought to the attention of members of The Medical Society of Nova Scotia, the Nova Scotia Branch of the Canadian Psychiatric Association, the section of Salaried Physicians of the C.M.A. and the Government of Nova Scotia."

Moved by Dr. F. A. Dunsworth, seconded by Dr. H. J. Devereux, "That the report of the Special Committee on Job Evaluation be adopted."

**Discussion**—It was agreed that this Committee continue to function. The motion for adoption was carried.

### Annual Meeting, 1959

Dr. Devereux, President, gave a verbal interim report on progress which had been made with his committees.

The possibility was discussed of having a conference of the Presidents and Secretaries of Branch Societies during the Annual Meeting. It was decided to write the Branch Societies of such a possibility and if attendance were sufficient, a time for the conference would be arranged.

**Re Golf Tournament.** This was introduced by Dr. Titus who inquired about prizes. The following Resolution was presented:

Moved by Dr. W. A. Hewat, seconded by Dr. F. J. Granville, "That up to \$50.00 be expended for golf prizes at the Annual Meeting, June, 1959." Carried.

Dr. Titus also noted that there were two cups available for prizes.

**Visiting team from C.M.A.** It was announced that, due to circumstances, there could not be a C.M.A. team attend our Annual Meeting for 1959. The C.M.A. had offered \$300.00 to cover expenditures involved in procuring speakers. The Secretary was authorized to accept this offer.

**The Report on Billing Physicians for Certain Laboratory Services** was presented by Dr. Rice. A letter from Dr. J. S. Robertson, Deputy Minister of Health, stated that after January 1, 1959, the laboratory charges not on the free list for non-hospital patients will be billed to the patient concerned, instead of the attending physician, providing there was adequate identification by the physician on the requisition form. This cleared up a matter which had been a matter of concern to the Society for some time. This information has been sent to all physicians by the Department of Health.

**Report on Office and Personnel.** This was a verbal report by the Secretary which included the following matters:

1. Insurance on Office Equipment. It was agreed that the Committee on Finance, which now also had the responsibility for property, be authorized to handle this.
2. The services of a full-time stenographer had been authorized at the October meeting. The Secretary had obtained the services of an efficient young lady but her plans were to leave the middle of April. The matter of salary for replacement was left to the Committee on Finance.
3. The office is now about completely furnished, there being a few items to be looked after.

The Treasurer, Dr. Titus, reported that the new system of bookkeeping, introduced in 1958 and continued in 1959, required that an accountant should act in a supervisory and advisory capacity with Mrs. Currie.

**A Report on Membership was Presented by Dr. Beckwith**

- (a) Report on Memberships as of December 31, 1958:

**MEMBERSHIP**

- (a) ACTIVE (Pay dues)

<b>CLASSIFICATION</b>	<b>1957</b>	<b>1958</b>
Ordinary conjoint.....	407	438
Ordinary, Medical Society only.....	12	9
Post-Graduate.....	34	45
First year practice.....	19	17
Second year practice.....	15	16
Retired.....	5	7
Non-resident.....	2	5
	<hr/>	<hr/>
	494	537*

- (b) Honorary and Senior (Do not pay dues)

Honorary and Senior.....	29	28
	<hr/>	<hr/>
	523	565

	<b>DEATHS</b>	<b>NEW MEMBERS</b>
1956	7	30
1957	16	57
1958	20	66
1959		
(To Jan. 26/59)		10
	<hr/>	<hr/>
	43	163

\*Dues for 1958 paid—There are 14 additional who have not paid dues for 1958. When these are paid, membership in good standing for 1958 will stand at 579.

(b) The names of these joining the Society since September, 1958, are as follows:

Bruce, I. F., Dartmouth, ordinary  
 Casey, M. T., Halifax, First year practice  
 Johnston, A. E., Halifax, Post-graduate  
 Mathieson, Robert, Sydney, ordinary  
 McJannett, Wm. A., Truro, ordinary  
 Park, J. N., New Glasgow, ordinary  
 Purkis, I. E., Halifax, ordinary  
 Saffron, Dorothy, Halifax, Post-graduate  
 Sinclair, A. McM., Halifax, First year practice  
 Tainsh, J. McN., Halifax, ordinary  
 Tompkins, K. J., Glace Bay, ordinary

Moved by Dr. H. J. Devereux, seconded by Dr. J. A. MacCormick, "That those as listed be accepted as members of The Medical Society of Nova Scotia." Carried.

#### Report from Divisional Member on C.M.A. Executive—Dr. R. O. Jones

This report gave information on the following points:

1. Joint B.M.A. - C.M.A. Meeting, July 18 - 24, 1959. Accommodation in Edinburgh is of "very high standard." The Duke of Edinburgh will be in Canada at the time of this meeting.
2. Difficulty has been experienced in completing arrangements for the installation of the Duke of Edinburgh as President of the Canadian Medical Association. It is probable that the ceremonies will take place in Montreal or Toronto, during the early days of the Royal Tour.
3. A very considerable time of the Executive meeting was devoted to a discussion regarding **Salaried Physicians**. It was recognized that this very important group of physicians has not been served as well as could be in the past and the C.M.A. would make a real effort to learn their difficulties and give help with hem. A questionnaire is being sent from the C.M.A. to each physician in Canada.
4. Work on the enlargement of C.M.A. House is expected to start in April, 1959.
5. There was discussion of problems which might arise as a result of D.V.A. hospitals coming under the Hospital Insurance plan. Patients not eligible for D.V.A. benefits can be admitted and the hospital bill will be covered by insurance. The payment of fees for medical services (uninsured) presents a problem and is being studied.
6. The All-Canadian programme of Hospital Accreditation became effective Jan. 1, 1959.

**Discussion**—Dr. Jones enlarged on each of the points in his report.

The Chairman, Dr. D. I. Rice, reported that the Society had been actively interested in salaried physicians in Nova Scotia for some time and had encouraged membership in the Society. A good number of salaried physicians are already members. The Executive Committee recognized the importance of the salaried physician and gave sympathetic consideration to their problems



and wish to do everything to encourage membership in the Branch Society, the Division and the Canadian Medical Association.

Resulting from the discussion, the following Resolution was presented:

Moved by Dr. H. J. Devereux, seconded by Dr. A. M. Marshall, "The Special Committee on Job Evaluation be asked to study the problems of all salaried physicians with special attention to the advisability of establishing a reduced membership fee for this group." Carried.

### **Committee to Study Annual Meetings**

Dr. Rice, a member of this Committee, introduced a questionnaire which it was proposed to send to each Branch Society for completion. He remarked that this matter had now been under study for two years, that the response of Branch Societies to questions had been disappointing and that this questionnaire was an effort to bring together the opinions of the Branch Societies. The Committee wished to have the Executive review the questionnaire for suggestions or approval.

The report and questionnaire were adopted.

### **Letter from Hospital Insurance Commission**

This was a request for an opinion as to whether a certain member of the Society was qualified in a Specialty. Discussion resulted in the following resolution:

Moved by Dr. F. A. Dunsworth, seconded by Dr. A. M. Marshall, "This Executive can only restate our general principles in maintaining a high professional standard in medicine and we cannot rightfully state or evaluate specialist qualifications." Carried.

The Secretary was instructed to write to Dr. Simms, Vice-Chairman, Hospital Insurance Commission, informing him of this Resolution.

### **Hospital Insurance-Out-Patient Services**

Dr. Granville drew to attention a press item relating to this subject in connection with the Aberdeen Hospital, New Glasgow. Dr. Granville was of the opinion that it placed The Medical Society in the position of being the scapegoat or, in other words, it was because of The Medical Society that out-patient services were not insured. It was his opinion that this adverse publicity, resulting from the manner in which the item had been reported in the press, should be corrected. Dr. Granville was assured that the matter had already been studied and it was pointed out that Mayor Logan had referred to "out-patient treatment" which is erroneous, what he should have referred to was "out-patient diagnostic service." A reply to Mayor Logan and the press had been considered but as this was a local matter it had been decided to see what would transpire at this meeting. The Committee on Public Relations, (Chairman, Dr. F. A. Dunsworth) was requested to continue study of the matter.

### **Approval of Expenditure**

The Chairman advised the Executive that it had been necessary to rent a room for the afternoon meeting and requested approval for the expenditure of the \$30.00 involved for this purpose. This approval was given.

On motion, the meeting adjourned at 10.15 p.m.

**N.B.**—Each member of the Executive has a copy of the full minutes.

C. J. W. BECKWITH, M.D.

## Secretary's Page

### Legislation - 1959

The Nova Scotia Chiropractic Association presented a 1959 edition of a bill "Respecting the Practice of Chiropractic." This (Bill No. 67) was presented for second reading on Thursday, March 12, 1959. The vote on second reading was 24 for and 14 against. It was referred to the Law Amendments Committee. It is of interest to note that of those who spoke in favour of a second reading, each stated to the effect that the bill was not acceptable in its present form.

The Amendments to the Medical Act were presented for second reading on the same date as Bill No. 74. There was explanation of the amendment pertaining to limiting the use of X-ray machines. The Bill was passed unanimously and referred to Amendments.

Bill 67 and Bill 74 were now fellow travellers through the Legislative procedures. The Public hearing for both was held on Wednesday, March 18.

It started at 10 a.m. and was adjourned at 2 p.m.; reconvened at 4 p.m. and completed at 5.30 p.m., a total of five and a half hours. Presentations for medicine in outright opposition to legal recognition of chiropractic were given by legal counsel for the Provincial Medical Board and The Medical Society followed by the viewpoint of the Clinician, expressed by Doctor J. McD. Corston. Doctor J. S. Manchester, radiologist, made a presentation relative to the use of X-ray and answered questions put to him by members of the Law Amendments Committee.

Medicine's opposition to Bill No. 67 was followed by the Chiropractors speaking in favour of it. They had no legal counsel. Three who had received treatment from chiropractors bore witness and presentations followed by a chiropractor and the President of that Association. The chiropractors gave outright opposition to the amendment in the Medical Bill relative to X-ray.

That is the situation as of March 20. The Committee on Law Amendments will make its recommendations known to the Legislature after this has gone to press. You will see or hear the results through the news media.

In the meantime, each Branch Society has been kept informed of what has transpired and the support of each in opposition to the Chiropractic Bill has been expressed to the local members of the Legislature.

C.J.W.B.

# Housing Application Form

The Medical Society of Nova Scotia

Keltic Lodge, Ingonish, N. S.

June 24, 25 & 26, 1959

MR. FRED IRWIN,  
Manager,  
Keltic Lodge,  
Ingonish, N. S.

Please reserve for me the following:—

**A. Main Lodge**

( ) Double room with bath—twin beds—including meals \$13.00 per day.

**B. In Cottage**

( ) Cottage with sitting room and two twin bedded bedrooms—including meals \$13.00 per person per day.

I WILL EXPECT TO ARRIVE JUNE..... A.M..... P.M.....

I WILL EXPECT TO DEPART.....

Names of persons who will occupy above accommodations:

Name (Dr. and Mrs).....

Address.....

In view of the large attendance expected, no single rooms will be available at the Keltic Lodge, unless cancellations permit. If coming alone please check here..... if you are willing to share a room. If you have a preference for some party to share a double room with (or couple(s) to share cottage with) please insert name(s) below:

I would prefer to share accommodation with

Name.....

Address.....

Name.....

Address.....

## THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA

The Atlantic Regional Meeting of The Royal College of Physicians and Surgeons of Canada will be held in Halifax, Nova Scotia, on Friday and Saturday, October 30 and 31, 1959, which are the last two days of the week of the Dalhousie University Refresher Course. This will be the first of such regional meetings sponsored by The Royal College in its programme to provide additional educational opportunities to members of the medical profession engaged in specialist practice.

A cordial invitation is extended to Fellows and Certificated Specialists of The Royal College of Physicians and Surgeons of Canada living in the Atlantic Provinces and Eastern Quebec to attend this meeting. There will be no fee for Fellows of the College; a registration fee of \$10 will be charged to all others attending the meeting.

The meeting will be divided into two sections, one for Medicine and the Medical Specialties and one for Surgery and the Surgical Specialties including Obstetrics and Gynaecology. The meetings will be held at Dalhousie University and its affiliated teaching hospitals. The programme will include presentations by a number of highly qualified guest speakers.

Fellows or Certificated Specialists of the College desiring to offer papers for presentation are requested to complete and forward the attached memorandum to the Chairman of the Programme Committee, Doctor R. C. Dickson, Suite 206, Out-patient Department, Victoria General Hospital, Halifax, **not later than May 1, 1959**, together with a brief abstract of the paper. Papers will be limited to fifteen minutes.

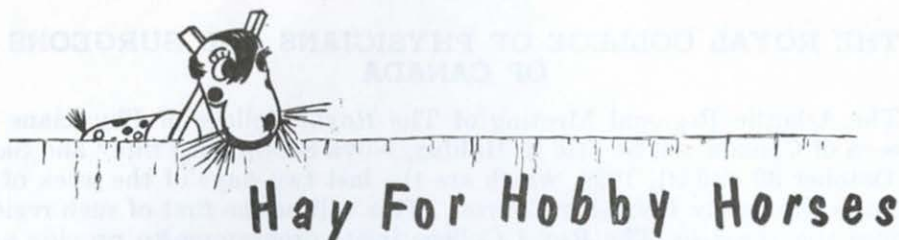
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## HALIFAX-DARTMOUTH BRANCH OF THE COLLEGE OF GENERAL PRACTICE

A meeting was held in the Dalhousie Public Health Clinic on January 28, 1959. The principal topic discussed was the difficulty in obtaining semi-private and private beds in the hospital for emergency cases, particularly with the increased demand due to the new Government Hospitalization plan.

A new slate of officers was elected for the year:

President	—	Dr. W. M. D. Robertson
Vice-President	—	Dr. S. G. B. Fullerton
Secretary	—	Dr. P. C. Gordon



March 1959

The hobby horse for this month is teaching. The magazine articles, addresses on radio and television, discussions among Home and School Associations and "bull sessions" among adults of all ages on the subject of teaching must total many millions of words each week. Such eminent magazines as Time, Atlantic, Life, Saturday Review and others have devoted entire issues to it. Without wishing to take sides on whether John Dewey is truly responsible for our present difficulties I would like to ruminate for a few minutes on this fascinating topic. These remarks were stimulated by the extremely pleasant experience of hearing Dr. George Wilson, our beloved Professor of History at Dalhousie speaking at the semi-annual meeting of the Dalhousie Alumni Association. In his address 'Thirty-Nine Years at Dalhousie,' Dr. Wilson said: "I have never met a student I did not like—I have met many I should have disliked but I never did.—" He recalled one of his distinguished colleagues in his early days at Dalhousie saying—"George, if they didn't pay us to teach I believe I would be doing it for nothing." Dr. Wilson went on to affirm that he has never regretted for a moment the long years he has spent at Dalhousie teaching his chosen subject of history. As he points out, history is the cement of all the other arts. Many of his pupils remember the excitement that was generated as they watched a rich tapestry of history, economics, philosophy, social science and many other elements of human knowledge emerging, without apparent effort, as Dr. Wilson talked. If, now 10, 15, 20 or more years after, we as engineers, accountants, physicians and housewives still cherish a small dream of personal enrichment through learning it is because of the influence of men like these. Despite the conflict about methods and content of teaching no one can doubt the profound influence that an effective and dedicated teacher has on those who listen to him. The influence may take years to become apparent or may only be recognized in retrospect as we remember some of our hours spent with affectionately-remembered teachers.

I have two books about teaching to draw to your attention this month. One, "The Art of Teaching" by Gilbert Highet (K1 Vintage Books 1954 New York), the other is "Teacher in America" by Jacques Barzun (a Doubleday Anchor Book A25). Both these books live up to the following description of one of them that appeared in the New Yorker. "Everybody in the teaching profession—and those less immediately involved with the subject will find his pages a mixture of sagacity and entertainment that makes them a constant delight." It is difficult to give even an inkling of the quality of these volumes but I will quote very briefly from Highet's book. "It is easy to like the young because they are young. They have no faults except the very ones which they are asking you to eradicate—ignorance, shallowness and inexperience. Heaven knows they are infuriatingly lazy and unbelievably stupid and sometimes detestably cruel but not for long and not all at once and not (like adults) as a

matter of habit or policy. They are trying to be energetic and wise and kind. When you remember this it is difficult not to like them. Of course nobody can bear young people all the time. —Remember you must not armour yourself against the energies of the young. You must not be a policeman watching the mob. You must be the leader of a group, something higher than the actor with his audience, something lower than the priest with his congregation, something kindlier than the officer with his unit. You must always feel what the orator feels when he addresses an audience partly friendly and partly docile and senses after a little that they are with him. It is essential to enjoy the conditions of teaching, to feel at home in a room containing twenty or thirty healthy young people and to make that enjoyment of group feeling give us energy for our teaching. In Barzun's book the casual reader might begin with Chapter 14—"The Ph.D. Octopus" which begins with a quotation from William James in an article of the same title. "The Ph.D. degree has become the union card for the American College Teacher. From the time when William James first raised his voice against the three letter fetish to the day when A. Lawrence Lowell established the society of fellows at Harvard in defiance of the need for degree hunting, the number of doctorates obtained has doubled and redoubled. In the last 15 years over forty thousand Ph.D.'s were made. A Young man on the education market without a Ph.D. must endeavour to look as if he were working for one—" Or in chapter 15, "Your I. Q. or Your Life." "In some progressive schools all tests have been abolished. This might look like a solution, were it not that examinations are a necessary and important part of instruction. In saying this I am not arguing from the practical need to give students marks. I refer to the student's need to learn how to jump hurdles. When I say this to a class that has just groaned and stamped its feet at the announcement of a test, there usually arises a spokesman of the Shattered Nerve brigade. He offers to tell me all I want to know, if only it can be done orally and not on paper. I accept and usually find that my bodily presence does not help him organize his knowledge, whatever may be the effect on his nerves. This fact is that the examination-shy are like fence-shy horses: they have been trained badly or not at all."

We are recognizing that we are all teachers to some degree and even the physician who only has intermittent contact with other physicians is still teaching by precept and example medicine as he sees it. He who teaches is taking a calculated risk. He wields a two-edged sword. We often teach much more than we are aware of—we set out to discourse on jaundice or heart disease or radiographic diagnosis. We may sow with out didactic wheat such tares as prejudice against physicians different than ourselves—attitudes of contempt for statistical methods, medical research, family practice or any other facet of this profession of which we are a part. This is a little recognized hazard of the job of teaching.

This week one of our local theatres is featuring an emetic movie called "Not as a Stranger" the marquee prefaces the title with the phrase "The Making of a Doctor." I recommend that any physician seeing the movie for the first time fortify himself with Graval before going to the theatre. When this picture first made the rounds in 1953 one of my psychiatric friends made the perceptive remark that the author, the late Morton Thompson, couldn't have known much about medical students because there was no horseplay in the book. He pointed out that horseplay was the safety valve that kept medical students sane. Thompson knew a great deal about the externals of the

profession, his description of the student's first day in the operating room, for example, is very good. But he has absolutely no feeling for the emotional environment of either the medical student life or the practice of medicine. In short, he never knew what made us tick. Incidentally, Morton Thompson, had an unrequited love affair with medicine. The book and the subsequent movie is a poor way to repay his beloved.

However all the blame is not Thompson's. I quote Stanley Kramer, the producer-director, of this fantasy when he explains why he chose one R. Mitchum to play the role of Lucas March in the movie. "In observing surgeons I have found that most of them are big rugged men. They are butchers, not in the derogatory sense but in the nature of the work they do. It takes a strong man to cut up human beings and to withstand the strain of hours over an operating table. That is why I picked strong personalities—Mitchum, Broderick Crawford, Charles Bickford—to play the surgeons in this picture." At the time I read this clipping I was working in a cardiac surgery unit. The principal surgeon could not have weighed any more than 120 pounds soaking wet. Does this sort of thing contribute to the public's picture of a physician and his profession? I sincerely hope not.

Fraternally yours,

BROTHER TIMOTHY.

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**The Postcholecystectomy Syndrome**, E. Kaiser, M.D., Zurich, Switzerland. *Journal of International College of Surgeons*, 31: 80-86, (Jan.) 1959.

As a result of the reexamination of 220 patients who had undergone operations on the gallbladder not less than a year and a half earlier, the author presents a thoroughgoing analysis of the results. He emphasizes the importance of radiomanometric study during the operation, which, together with cholangiographic investigation, makes it a rare occurrence for stones to be left behind in either the cystic duct or the common bile duct. Overlooked stones and pathologic conditions in the bile ducts therefore command less concentrated attention from the surgeon than do hepatic changes that existed prior to operation, especially cholangitis, interstitial hepatitis and the various types of cirrhosis. Since these diseases are most frequently due to long-standing disease of the gallbladder, they should prove preventable, in many cases, by surgical intervention before complications occur. Absolute contraindications, such as extreme age, arteriosclerotic dementia and extraordinary obesity, are still valid except when the severity of the symptoms make operation unavoidable.

## Personal Interest Notes

Doctor J. M. Corston, Halifax, has been elected a Fellow of The Royal College of Obstetrics and Gynaecology of London. A member of the Medical Faculty of Dalhousie University, Doctor Corston received his membership in The Royal College in 1947.

A graduate of Edinburgh University Doctor Corston served overseas during World War II with the rank of Captain, Royal Canadian Medical Corps. He has been a member of the Department of Obstetrics and Gynaecology Dalhousie University and Victoria General Hospital for the past nine years.

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Doctor John Edmond Bethune of Berwick, B.A., S.Sc., Acadia, a graduate of Dalhousie Medical College 1952, has been appointed to the Department of Medicine as an Endocrinologist.

Doctor Bethune has had extensive post-graduate studies over the past six years in Boston and the Royal Victoria Hospital, Montreal. During the past year he has been in England as a McLaughlin Fellow. In 1957, Doctor Bethune obtained his F.R.C.S. (Medicine) Canada.

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Three Dalhousie University Medical researchers have been awarded National Heart Foundation Fellowships. They are Don P. MacLeod, M.A. for his work in the study of fundamental causes of abnormal heart rhythms with reference to the importance of body salts, and Doctor Samuel J. Shane and Doctor Donald S. Beansland were jointly awarded for making "comparisons by various methods of the volume of blood flow from healthy and diseased hearts."

The Fellowships permit new and continued investigation of the causes, effects, treatments and prevention of Canada's No. 1 crippling and mortality illness.

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Doctor Hereford C. Still was elected President of the St. George's Society of Halifax at the 173rd meeting of the organization held recently in the city.

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Doctor A. W. Ormiston presented his resignation as physician to the County of Cape Breton Hospital on Monday, February 23rd. Doctor Ormiston was recently appointed medical examiner for the Dominion Steel-workers Mutual Benefit Society.

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Doctor Edward Alexander Nugent, who graduated from the University of Toronto Medical School with his M.D. in 1952, has been appointed Assistant Professor of Surgery, Dalhousie Medical School and Attending Surgeon, Victoria General Hospital. This is a full-time appointment.

Doctor Nugent carried out post-graduate training in physiology under Doctor A. M. Rappaporte from 1953 to 1954. From 1954 to 1956 he was on the Toronto General Hospital Rotating Services. He spent six months in



orthopaedic surgery at St. Joseph's Hospital. Toronto in 1857, and from 1957 to 1958 he studied thoracic surgery at Frenchay Hospital, Bristol, England. Doctor Nugent obtained his F.R.C.S. (Canada) in the Fall of 1958.

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Doctor N. H. Gosse of Halifax has been honoured for his work in cancer control at the annual meeting of the Nova Scotia Division, Canadian Cancer Society. A presentation of Scrolls was made by Doctor J. P. McGuigan, the Society President. Doctor Gosse has resigned from the Provincial Board but is still a member of the Dominion Board of the Canadian Cancer Society.

At this meeting, Doctor J. G. Kaplan, Assistant Professor of Physiology at Dalhousie University, gave a paper "Two Thousand Years of the Cancer Problem."

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### **The Uterus and the Products of Inflammation: Fundal Keloid?**

Thomas B. Noble, M.D., Indianapolis. *Journal of International College of Surgeons*, 31: 30-37, (Jan.) 1959.

On the basis of a study in which the "standard" hematoxylin-eosin stain and Masson's trichrome stain were compared as to their respective value in revealing the presence, nature and causes of uterine disease, the author reports his conclusion that Masson's trichrome reveals a startling number of highly significant diagnostic points not even suggested by a specimen stained with hematoxylin and eosin. To the fact that the latter stain is used routinely and without question in many hospitals he attributes the frequent neglect of conditions requiring surgical intervention, which in turn, in many cases, accounts for the eventual alteration of a potentially normal woman to a "pelvic cripple." In support of this conclusion he presents color photomicrographs of two immediately adjacent portions of the same specimen, one stained with hematoxylin and eosin and the other with Masson's trichrome, as well as a tabulation of relevant statistical data in 25 cases. He lists his observations specifically and in detail and presents a series of diagnostic and therapeutic recommendations based on the striking contrast of the pathologic picture as revealed by these two stains.