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The NOVA SCOTIA MEDICAL BULLETIN

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EDITORIAL

WANTED! MEN OF ILL-WILL

The question is often asked: "Why do so few men attend the business meetings of The Medical Society of Nova Scotia?" There are some possible explanations. One is the change in the constitution which has taken the power of primary debate and decision from the floor of the general meeting, and left only insipid rubber-stamping within the purlieu of the ordinary member's activity. It is senseless to argue that the power of veto still lies with the meeting. On paper, yes; in actual practice it does not, for it takes a tremendous effort by a well-organized group to reverse the decision and recommendation of an official executive body.

This change in the constitution was made for the express purpose of streamlining business and getting decisions firmly made on matters which previously were often smothered aborning because of conflicting interest in the general meeting. It could be that such premature demise was the meet and proper end for many of the items brought for debate before these meetings,—for time has shown them to be often ill conceived, inadequate and weak. However, the change having been made, the power to act centralized, the general meeting emasculated, let us not stand in shocked wonder at the small attendance, but, to keep our membership informed, rely on a media far more accurate, if less warm and colorful than speech,—the printed word. This means more Bulletin space devoted to business and your letters of comment. *See you to it!*

Another truly deplorable factor in the declining attendance figures may be that many members have lost faith in the ability of organized medicine to effectively control or alter the changes threatening the future of medical practise. Worldwide experience has shown, with few exceptions, that when government enters the field of medical care, medicine finds itself in the arena of politics.

Matters extremely vital to the practice of medicine come under the influence and pressure of the drive for votes and these matters can be altered, stayed or turned aside only by political activity more powerful than the forces opposing. Every layman knows this; most doctors close their eyes to it. Wherever organized medicine has taken the only steps possible to counter political invasion, they have been accused, by some doctors, of using despicable methods and thereby lowering the dignity and prestige of medicine.

One is forced to the belief that many of our colleagues would have us grovel before these polititicans in introspective self-denunciation, and plead with noble humility for justice. But rather is this a time when a rugged corps

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

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President-Elect	R. F. Ross
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AFFILIATE SOCIETIES	PRESIDENT
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Nova Scotia Society of Ophthalmology & Otolaryngology	E. I. Glenister
Nova Scotia Society of General Practitioners	A. G. MacLeod
Nova Scotia Chapter of College of General Practice	A. Titus
Nova Scotia Division of Canadian Anaesthetists' Society	C. H. L. Baker
Nova Scotia Association of Pathologists	J. H. Cooper

of men of ill-will should stand up in the fierce pride of Medicine's vast achievement under free enterprise and fight with tooth and nail for the preservation of complete corporate determination and corporate control. Any other attitude leaves only prayer as a defensive method, so it is understandable if many members feel that the quiet atmosphere of home is more conducive to earnest suppliance than the raucous turbulence of a general meeting.

There is no middle course! Do we stand up and fight with the weapons of effective defence? Or do we kneel down and pray?

J.W.R.

"In my experience the well-educated physician who had excellent undergraduate education and three or four years of outstanding staff training can greatly profit from a series of lectures about the progress of medicine, actually our main vehicle of post-graduate education. Unfortunately, the group of such well-educated physicians does not represent the total medical population. The physician who did not graduate from a top-rank medical school, who perhaps had a poor internship and no residency training, needs post-graduate education the most. That is, a sizeable number of practicing physicians are in need of training at the bedside, under careful supervision and with a certain amount of responsibility."

Dr. Isidore Snapper, Director of Medicine and Medical Education, Beth-El Hospital, Brooklyn, N. Y., in "Conference" August 1960.

"Lectures directed to relatively large audiences deviate from the soundest principle of American medical education. The main part of medical education in general, of post-graduate education in particular, should consist of the teaching of clinical experience well integrated with basic science with active student participation. Such courses which would attract general practitioners should be given by clinician-scientists who are accustomed to training house-staff members. There are large groups of physicians who are hungering for such integrated instruction in the progress of medicine which has been made since they started their practice."

Dr. Isidore Snapper, Director of Medicine and Medical Education, Beth-El Hospital, Brooklyn, N. Y., in "Conference" August 1960

"Unfortunately part of our problem is that a large number of the people who need post-graduate or continuing education do not recognize their need, or if they do recognize it, ignore it in one way or another. How to reach these people is a most important problem."

Dr. Douglas D. Vollan, Formerly Assistant Secretary, Council on Medical Education and Hospitals, American Medical Association, in "Conference" August 1960.

THE CANADIAN MEDICAL ASSOCIATION
STATEMENT OF MEDICAL SERVICES INSURANCE

The Canadian Medical Association believes that:

The highest standard of medical services should be available to every resident of Canada.

Insurance to prepay the costs of medical services should be available to all regardless of age, state of health or financial status.

Certain individuals require assistance to pay medical services insurance costs.

The efforts of organized medicine, governments and all other interested bodies should be coordinated towards these ends.

While there are certain aspects of medical services in which tax-supported programs are necessary, a tax-supported comprehensive program, compulsory for all, is neither necessary nor desirable.

The Canadian Medical Association will support any program of medical services insurance which adheres to the following principles:

1. That all persons rendering services are legally qualified physicians and surgeons.
2. That every resident of Canada is free to select his doctor and that each doctor is free to choose his patients.
3. That the competence and ability of any doctor is determined only by professional self-government.
4. That within his competence, each physician has the privilege to treat his patients in and out of hospital.
5. That each individual physician is free to select the type and location of his practice.
6. That each patient has the right to have all information pertaining to his medical condition kept confidential except where the public interest is paramount.
7. That the duty of the physician to his individual patient takes precedence over his obligations to any medical services insurance programs.
8. That every resident of Canada, whether a recipient or provider of services, has the right of recourse to the courts in all disputes.
9. That medical services insurance programs do not in any way preclude the private practice of medicine.
10. That medical research, undergraduate and post-graduate teaching are not inhibited by any medical services insurance program.
11. That the administration and finances of medical services insurance programs are completely separate from other programs, and that any Board, Commission or Agency set up to administer any medical services insurance program has fiscal authority and autonomy.
12. That the composite opinion of the appropriate body of the medical profession is considered and the medical profession adequately represented on any Board, Commission or Agency set up to plan, to establish policy or to direct administration for any medical services insurance program.
13. That members of the medical profession, as the providers of medical services, have the right to determine the method of their remuneration.
14. That the amount of remuneration is a matter for negotiation between the physician and his patient, or those acting on their behalf; and, that all medical services programs make provision for periodic or automatic changes in remuneration to reflect changes in economic conditions.

June, 1960.

As an introduction to the "Statement" (given above) paragraph No. 134 and No. 135 General Council Reports are pertinent:

"134. You were informed at the last meeting of the General Council that the Committee on Economics was considering the present statement of Principles and

Policies with a view to determining the extent to which it accurately or adequately expresses our views. Subsequent to discussion of questions posed by staff—(a prepared memorandum on 'The Interest of Government in the Practice of Medicine') the Committee on Economics appointed a small sub-committee to hold further discussions and to prepare a draft of a revised C.M.A. statement which would take into consideration changes in the attitude of the profession and changes in the mechanisms for health care prepayment. This sub-committee met on two occasions and then after consultation with the General Secretary, Dr. A. D. Kelly, presented a draft document. This was studied by the Committee on Economics in November, 1959, passed back to the sub-committee and studied again by the Committee in March, 1960.

135. The Committee on Economics considered that the terms Health Insurance and Health Care were capable of too broad an interpretation and have recommended the use of terms "Medical Services" or Medical Services Insurance' where they are applicable. The following factors and attitudes also formed the basis for the Committee's conclusions:

1. That it is important that a statement be prepared which indicates very clearly the attitude and motivation of the profession towards medical care insurance.
2. That the Statement should be related specifically to medical services as hospitalization is now a fait accompli.
3. That medicine should take the initiative in recommending the study and evolution of medical services insurance programs.
4. That joint study of such problems with other agencies does not preclude active opposition to any plan which did not meet with our approval.
5. That the principles set out represent basic essentials which should be acceptable *without negotiation.*
6. That other factors such as fee-for-service, adequate remuneration etc. are important but they are subject to so many qualifications or exceptions that they should be considered *factors for negotiation.*"

These two paragraphs were formally adopted.

Transactions

5TH REGULAR MEETING EXECUTIVE COMMITTEE
9.30 A.M. SATURDAY, JUNE 25TH, 1960 AT
WHITE POINT BEACH

The meeting convened at 9.45 a.m. with Dr. D. I. Rice as Chairman. This meeting had three sessions:—(1) 9.45 a.m.-12.30 p.m. (2) 2.30 p.m.-6 p.m. (3) 8 p.m.-10 p.m.

Dr. A. A. Giffen, Dr. G. M. Saunders and Dr. J. O. Godden were welcomed as alternates for the elected representatives from the Valley Medical Society, the Cumberland Medical Society and the Editor of The Nova Scotia Medical Bulletin respectively.

Present were:—

PRESIDENT:	Dr. W. A. Hewat, M.D.
PRESIDENT-ELECT:	Dr. F. J. Granville, M.D.
PAST-PRESIDENT:	Dr. H. J. Devereaux, M.D.
CHAIRMAN, EXECUTIVE:	Dr. D. I. Rice, M.D.
TREASURER:	Dr. A. W. Titus, M.D.
ANTIGONISH-GUYSBOROUGH:	Dr. T. W. Gorman, M.D.
CAPE BRETON	Dr. H. F. Sutherland, M.D.
COLCHESTER-EAST HANTS	Dr. S. G. MacKenzie, M.D.
HALIFAX:	Dr. D. M. MacRae—Dr. A. M. Marshall—Dr. J. S. Robertson
LUNENBURG-QUEENS:	Dr. S. B. Bird, M.D.
PICTOU COUNTY:	Dr. M. F. Fitzgerald, M.D.

Observers

Dr. R. O. Jones—Representative to C.M.A. Executive Committee.
Dr. F. A. Dunsworth—Chairman, Public Relations Committee.
Dr. A. L. Sutherland—Chairman, Medical Economics Committee.
Dr. A. F. W. Peart—Deputy General Secretary, C.M.A.

Minutes of Previous Meeting

Adoption of the Minutes of the 4th regular meeting (May 9th, 1960) were moved and seconded for adoption. One statement was questioned and the Minutes adopted as amended.

Business Arising from the Minutes

(a) **Senior Membership** in The Medical Society of Nova Scotia. Dr. D. F. McInnis of Shubenacadie was elected.

(b) Legal protection in discharge of their duties for medical members of the Hospital Standards Committees:—A communication from the Nova Scotia Hospital Commission in reply to inquiries was read. This communication included the Nova Scotia Hospital Act and regulations.

(c) Opinions re "Incomes of physicians who provide diagnostic services under Nova Scotia Hospital Insurance Plan." This communication from the legal counsel for the Society was read and discussed. It was moved, seconded and carried that the letter be accepted.

(d) Re Executive resolution (May 9th)—"Signed releases by patients." The request by the Chairman of the Committee on Legislation and Ethics that this be delayed resulted in the following resolution:—

> "That action be deferred until the Chairman of the Executive Committee deems the time appropriate."

Carried.

(e) Re letter to Branch Societies requesting scheduled meetings. The Secretary explained that action on the resolution from the meeting of May 9th had been delayed to permit further clarification by the Executive. Extended discussion resulted in the following resolution:—

"That the Secretary of The Nova Scotia Medical Society arrange with the various Branch Societies through their Secretaries a schedule of quarterly Branch Society meetings each year; that these meetings be so arranged as to be held prior to Executive meetings and that these meetings be attended as often as possible by the Secretary or a suitable representative of the Executive." Carried.

(f) Expenses for representatives attending Executive Committee meetings. This subject was introduced for the purpose of clarification by the Executive Committee. After review of the background and discussion the following resolution was carried:—

"That the previously passed resolution of the Finance Committee concerning payment of representatives to the Executive meetings rescinded and the following be substituted; that representatives be paid travelling expenses of .12c per mile and $10.00 for any additional days. Meetings of Executive that extend past 7 p.m. be considered an additional day. This does not apply to Annual Meeting of Executive."

Committee Reports

1. Committee on Public Relations.

Dr. F. A. Dunsworth, Chairman, outlined the plans for the public information services for the present Annual Meeting. These were approved.

2. Special Committee on Group Disability Insurance.

In the absence of the Chairman of this Committee the Secretary gave an outline of developments since the last Executive Meeting. It is expected to have definite information for the second regular meeting in October, 1960.

3. Special Committee on Salaried Physicians.

A proposed questionnaire to be sent to "salaried physicians" was received and resulted in a revised questionnaire to be forwarded for consideration by that Committee.

Doctors T. W. Gorman and A. A. Giffin were elected to be members of the Resolutions Committee, Chairman Dr. A. M. Marshall.

Second Session

Committee reports continued.

4. Committee on Health Insurance.

After lengthy discussion it was agreed to adopt this report, the Chairman having ruled that the Brief from the N.S.A.R. (June 10th) would be considered separately from the report itself. Dr. C. B. Stewart, Chairman of the Committee and Dr. C. M. Jones, President of the N.S.A.R. will be invited to attend the Annual Meeting of the Executive to reply to questions.

5. Committee on Medical Economics.

Dr. A. L. Sutherland, Chairman reported that the agreement with the Department of Public Welfare had been completed and that a communication, mutually satisfactory to the Department and the Medical Society, is being developed to send to the recipients of medical services.

Report on General Council, C.M.A. 1960 (Banff).

Dr. Beckwith reported that the nine representatives from Nova Scotia had attended all sessions of General Council. A meeting of our representatives had taken place the night prior to the sessions and that a further report would be presented to the fall meeting of the Executive Committee.

Communications

The following communications were presented:—

(a) Letter from Dr. L. C. Steeves, President, the Nova Scotia Society of Internal Medicine. Discussion led to the following resolution:—

"That the Executive approve the above Society in its stand on following—(1) the fee for reading E.K.G.'s and E.C.G.'s set by Nova Scotia Medical Society in its Schedule of Fees (2) That the fee for second and subsequent readings of E.C.G.'s and E.K.G.'s on the same patient (within 14 days) be referred to the Tariff Committee for conconsideration."

Carried.

(b) Letter from Secretary, Nova Scotia Society of Internal Medicine (Dr. N. H. A. MacDonald) requesting information relative to that Society obtaining recognition by The Medical Society of Nova Scotia was referred for presentation under report of Committee on By-laws.

(c) Letter from Secretary, Nova Scotia Dental Association re remuneration for dental surgeons for dental surgical services provided to subscribers of M.M.C. Inc. Discussion resulted in the following resolution:—

"That the Executive re-affirm their stand taken previously on the matter of M.M.C. paying dentists for dental surgery."

Carried.

(d) Letter from Dr. H. H. Tucker re Blue Shield "Supplementary type of contract." After discussion it was agreed to inform Dr. Tucker of the opinion of the Executive.

(e) Letter from Dr. J. F. L. Woodbury, Medical Director, Nova Scotia Division, Canadian Arthritis & Rheumatism Society requesting consideration of a statement of the National Medical Advisory Board with a view to endorsation. The following resolution was carried:—

"That this Society endorses the recommendation of the Nova Scotia Division of the Canadian Arthritis and Rheumatism Society that further physiotherapy treatment centres be established with the exclusion of the medical profession component."

(f) Replies from the Nova Scotia Hospital Insurance Commission to letters from The Medical Society of Nova Scotia relative to—

i. Disclosure of hospital records to Nova Scotia Hospital Insurance Commission. Received as providing necessary information.

ii. Remuneration of Chairmen of Medical Sub-Committees of Hospital Standards Committees for attending meetings called by the Nova Scotia Hospital Insurance Commission. The Commission has agreed to this.

iii. Medical Review Board. The Executive agreed with the contents.

(g) Letter from Nova Scotia Section Canadian Psychiatric Association was received but no action except to await any further communication from this group.

(h) Institute of Pastoral Training. A personal communication was presented by a member for advice relative to the resolution from the Executive Meeting of May 9th.

New Business

The following resolutions were presented:—

Three resolutions from the Cumberland Medical Society—

1. ". . . . . being in favor of physicians' services for autopsies and court appearances being remunerated in accordance with the Fee Schedule . . . . ."

Discussion resulted in the following resolution:—

"That the Secretary of The Medical Society of Nova Scotia communicate with the Attorney General's Department re payment of physicians' services for autopsies and court appearances, indicating the Nova Scotia Fee Schedule for these services. Also that information be requested regarding the "Medical Examiner" system which is to replace the present "Coroner" system."

Carried.

2. ". . . . .endorsing the principle of Fee for Service. . . . ."

and 3. ". . . . .re-affirming its confidence in the representative to the Executive Committee. . . . ."

were accepted as information.

Three resolutions from the Valley Medical Society:

1. ". . . . .opposition to the low fees of the Nova Scotia Workmen's Compensation Board and proration of D.V.A. accounts. . . . ."

Explanation was given of the standing of both these matters and both will be followed up.

2. Resolution based on "the adverse publicity received by the medical profession on generic versus trade names of drugs." Requested that a "brief" be prepared stating the "opinion of organized medicine on the necessity of maintaining research, purity of drugs, standardization of dosage. . . . ."

This resolution was received.

3. A resolution which ". . . . .disapproved of the adverse publicity. . . . ." resulting from a presentation regarding infant and maternal mortality.

This was referred to the Committee on Public Relations.

A proposed agreement between The Medical Society of Nova Scotia and M.M.C. Inc., was approved. This is for the purpose of handling the funds for medical services to certain Social Assistance groups.

Authority was given to create a Committee on Pharmacy.

Authority was given to create a Committee on Nutrition.

The Executive Secretary requested the Executive to consider whether he should become a member of the Canadian Medical Protective Association. The Executive did not consider this necessary.

A communication had been received inviting a representative to attent the 16th Annual Meeting of the Western Conference on Prepaid Medical Plans. Additional information was requested prior to making a decision.

C.M.A. "Statement on Medical Insured Services."

This was presented as follows:—

Dr. R. O. Jones, Divisional representative to the C.M.A. Committee and Chairman of the Resolutions Committee of General Council, 1960 gave a summary of the development of the "Statement" at the C.M.A. Executive Committee and General Council, also giving an outline of the action taken by General Council in reference to the situation in Saskatchewan.

This was followed by an extended discussion in which all members of the Executive Committee took part and resulting in the following resolution:—

"That the Executive appoint a committee of five representing the province to study the C.M.A. Statement on Medical Services Insurance with a view to finding a practical application to the problem in Nova Scotia."

Carried.

The 5th regular meeting of the Executive Committee by resolution adjourned at 10 p.m.

C.J.W.B.

Transactions

First Meeting of New Executive (1960-1961)

June 30th, 1960

WHITE POINT BEACH

The Chairman, Dr. D. I. Rice called the meeting to order at 11.30 a.m.

Present were:

*President:	F. J. Granville, M.D.
Chairman, Executive:	D. I. Rice, M.D.
Treasurer:	A. W. Titus, M.D.
Editor, Bulletin:	J. O. Godden, M.D. (alternate for S. J. Shane, M.D.)
Executive Secretary:	C. J. W. Beckwith, M.D.

Representatives from Branch Societies:

Antigonish-Guysborough	T. W. Gorman, M.D.
Cape Breton:	A. L. Sutherland, M.D. (alternate for J. R. Macneil, M.D.)
Cumberland:	G. M. Saunders, M.D.
Halifax:	J. A. Myrden, M.D. (alternate for J. W. Merritt, M.D.)
*	F. J. Barton, M.D.
Pictou: :	M. F. Fitzgerald, M.D.
Valley:	D. MacD. Archibald, M.D.

The Chairman welcomed the members to the first meeting of 1960-61 and particularly the new representatives to the Executive Committee.

It was agreed that the minutes of the last regular meeting, June 25th, 1960 will be presented to the second meeting of the Executive 1960-61.

The Chairman stated that the Committee on Committees had not yet finished its review of Committees. It was agreed to have that Committee report its recommendations and that the Executive Committee as a whole would continue the deliberations on Committee Chairmen.

The following were elected:

A. Chairmen of Standing Committees.

Committee	Chairman
Archives	C. M. Bethune, M.D. (1)
By-laws	H. J. Devereux, M.D. (2)
Cancer	W. R. C. Tupper, M.D. (2)
Child and Maternal Health	M. G. Tompkins, Jr., M.D. (2)
Civil Disaster	S. B. Bird, M.D. (1)
Editorial Board	S. J. Shane, M.D. (2)
Fees	H. B. Whitman, M.D. (1)
Finance	J. J. Charman, M.D. (2)
Health Insurance	C. B. Stewart, M.D. (2)
Legislation & Ethics	D. F. Smith, M.D. (2)
Medical Economics	H. E. Christie, M.D. (1)
Membership	D. M. MacRae, M.D. (2)
Nutrition	W. A. Cochrane, M.D. (1)
Pharmacy	R. M. MacDonald, M.D. (1)
Post-Graduate Education	D. C. P. Cantelope, M.D. (1)
Public Health	S. D. Dunn, M.D. (1)
Public Relations	F. A. Dunsworth, M.D. (2)
Rehabilitation	A. H. Shears, M.D. (2)
Traffic Accidents	A. L. Murphy, M.D. (2)

(1) newly elected (2) re-elected.

It is to be noted that the Committees on Archives, Nutrition and Pharmacy are new Standing Committees.

B. Chairmen of Special Committees.

Group Disability Insurance - - - - - - - - J. W. Merritt, M.D.
Salaried Physicians - - - - - - - - - - A. G. MacLeod, M.D.
Study of Annual Meetings - - - - - - - - - D. I. Rice, M.D.
Federal-Provincial Health Grants - - - - - - C. J. W. Beckwith, M.D.
Workmen's Compensation Board - - - - - - - - A. W. Titus, M.D.

C. Representatives to Organizations.

Board of Trustees Mar. Hospital - - - - (H. E. Christie, M.D. (1960-63)
Services Association - - - - - (C. J. W. Beckwith, M.D. (1959-62)
Board of Registration, Certified
Nursing Assistants' Association - - - C. J. W. Beckwith, M.D. (1960-63)
Canadian Cancer Society - - - - - - - - W. R. C. Tupper, M.D.
Executive Committee, C.M.A. - - - - - - - - R. O. Jones, M.D.
Board of Governors, V.O.N. of Canada & Medical Advisory
Board, N. S. - - - - - - - - - - - - J. J. Stanton, M.D.
Trusteeship Committee, C.M.R.S. Plan - A. W. Titus, M.D., C. H. Young, M.D. (alternate)
Dalhousie Medical Library Committee - - - - - A. W. Titus, M.D.

New Business.

A Committee under the Chairmanship of Dr. M. F. Fitzgerald, New Glasgow, was authorized to make recommendations to the Executive Committee re presidential insignia, lapel buttons for past-presidents, a parchment or similar token to present to Senior Members and certificates for Branch Societies.

Approval of the report of the Committee on Health Insurance required the election of three from six nominations from the N.S.A.R. to be members of the Radiology Standards of The Medical Society of Nova Scotia.
Those elected were:—

A. J. M. Griffiths, M.D., Liverpool.
H. R. Roby, M.D., Windsor.
C. M. Jones, M.D., Halifax.

Other members are to be:—Chairman of the Committee on Health Insurance or a member named by that Committee;—The Nova Scotia Hospital Insurance Commission is to be invited to name a medical member of the Professional Technical Advisory Committee.

The following resolution was presented. It had been passed at the Regular Meeting of Executive June 25, 1960.

"That the Executive appoint a committee of five representing the Province to study the C.M.A. Statement on Medical Services Insurance with a view to finding a practical application to the problem in Nova Scotia."

After discussion it was agreed that a Special Meeting of the Executive would be called for the purpose of implementing this resolution.

It was recognized that the position of the Health Insurance Committee would have to be determined in view of the proposed "study group." Dr. C. B. Stewart will be requested to continue as Chairman of the Health Insurance Committee until the Executive has made its decision.

It was agreed that members making application for accommodation at Annual Meetings should receive confirmation or otherwise of reservations.

The meeting was adjourned at 1.30 p.m.

C.J.W.B.

Transactions

SPECIAL MEETING

Executive Committee — Sept 10, 1960

Summary of action taken relative to "Special Study Group" now identified as SPECIAL RESEARCH COMMITTEE OF THE MEDICAL SOCIETY OF NOVA SCOTIA.

At the general session of the Annual Meeting 1960, during the debate on the C.M.A. Statement on "Medical Services Insurance" the following resolution was unanimously adopted:—

> "That The Medical Society of Nova Scotia at this general meeting (1960) goes on record and is in accord with a plan for medical services insurance for Nova Scotia so that the highest possible quality of medical services will be available irrespective of income; and furthermore, The Medical Society of Nova Scotia believes that this can be brought about by the united efforts and co-operation of existing agencies interested in and responsible for the health of the people of Nova Scotia."

The C.M.A. Statement had been considered by the 5th meeting of the Executive (June 25/60) when the following resolution was carried:—

> "That the Executive appoint a Committee of five representing the Province to study the C.M.A. Statement on "Medical Services Insurance" with a view to finding a practical application to the problem in Nova Scotia."

A special meeting of the Executive Committee was called for September 10th, 1960 for the purpose of discussing and naming what was then identified as the "Study Group."

The action of the Executive at this meeting on September 10th is summarized as follows:—

(1) Agreed that the "Study Group" is a necessity.

(2) Agreed that a Committee on Health Insurance would continue under its present terms of reference and that the "Special Study Group" would not transgress the present terms of the Health Insurance Committee. This decision was based on the premise that the day to day matters dealing with medical services under the Hospital Insurance Act and related subjects would require the attention of this committee.

Dr. N. K. MacLennan of Sydney was elected as Chairman and has accepted.

(3) Agreed that the name for this "Study Group" would be:—

SPECIAL RESEARCH COMMITTEE OF THE MEDICAL SOCIETY OF NOVA SCOTIA. (S.R.C.)

This name was chosen after considerable discussion. It seemed to define the purpose for the Committee which is to report to the Executive Committee findings and recommendations relative to the extension of medical services. The name for the Committee is intended to imply complete freedom for inquiry, the preparation of reports and recommendations.

(4) Agreed that, members of the S.R.C. having been identified, the Committee would be convened and be requested to prepare a progress report, which would include terms of reference, financial aspects, secretarial assistance required and possibly an outline of the Committee's approach to the problem. The second regular meeting of the Executive is on Saturday, October 15th, 1960.

(5) Agreed that the S.R.C. be informed of the discussion at this Executive Committee for the purposes of information when considering its terms of reference.

A summary of the discussion is as follows:—

(a) That the S.R.C. consider appointing corresponding members.

(b) That the Committee be assured of the co-operation of all members of the Society and that it feel free to approach any member for information or opinion.
(c) That it consider having available legal advice.
(d) That the Committee feel free to call on any source for information.
(e) That the terms of reference for the Ontario Medical Association "Committee on Medical Care" might assist in the preparation of terms of reference for the S.R.C. These are published in the August, 1959 issue of the O.M.A. Journal, page 127.
(f) That arrangements be made with the C.M.A. to provide any possible assistance.

(6) Agreed that a ballot be held on the names (nineteen) submitted by members of the Executive to determine the five who would constitute the S.R.C. and that the S.R.C. elect its own Chairman at the time of its first meeting.

The resulting ballot elected to the Committee the following members:—

Dr. R. O. Jones, Halifax.
Dr. J. A. McDonald, Glace Bay.
Dr. J. W. Reid, Halifax.
Dr. C. B. Stewart, Halifax.
Dr. A. A. Giffin, Kentville.

(7) Agreed that the Chairman of the Executive Committee convene the first meeting of the S.R.C. at which the members will elect their Chairman. (The date for the first meeting of the S.R.C. is Saturday, September 24th, 1960. Notice was mailed to the members on September 14th, 1960).

Report of the Committee on Health Insurance—Chairman, Dr. C. B. Stewart.

At the first meeting of the Executive 1960-1961, Dr. C. B. Stewart had been re-appointed Chairman. He had been informed of the Special Meeting of the Executive at which the position of the Committee on Health Insurance would be examined in relationship to the new committee now identified as the Special Research Committee. The report of his committee presented the matters dealt with in the interval June 30, 1960 to September 9, 1960. The report included a request that the Executive accept the resignation of the Chairman and members, based on the premise that the Executive Committee should have complete freedom to plan for the future. The report was adopted.

The following is a background for the Committee on Health Insurance:

Background of Committee on Health Insurance

The name "Committee on Health Insurance" was deliberately chosen when the terms of reference for the present Standing Committee were defined (1957). The purpose was to denote that this Committee had responsibility, not only in the area of Hospital Insurance, but also in that which is now termed "Medical Services Insurance"; this latter terminology was accepted at General Council (C.M.A.) in 1960, because the term Health Insurance might be interpreted to include interests peripheral to those of medicine.

The prime interest of the Committee on Health Insurance has been Hospital Insurance and diagnostic services. It is interesting to note the chronology of the development within The Medical Society of Nova Scotia.

1955—On invitation by the government a representative of the Society was appointed to the Planning Committee of the Government of N. S.

1956—Advisory Committee on Health Insurance created by the Society.

1957—Standing Committee on Health Insurance replaced the Advisory Committee with terms of reference as follows:—

> "The present special advisory committee on Health Insurance be made a standing committee, with all the powers pertaining thereto, and further the terms of reference of this committee be broadened to permit the committee to participate in or initiate discussion with government or other interested groups."

From the standpoint of Government—

1955—Planning Committee for Government was created. The Medical Society of Nova Scotia invited to name a representative. That Committee was to enquire into the feasibility of a Hospital Insurance Plan for Nova Scotia and to report its recommendations.

Its function was terminated when the report was presented to Government. Resulting from this report—

1957—saw legislation to create a Hospital Service Planning Commission. This Commission had an Advisory Committee to which The Medical Society of Nova Scotia was invited to submit nominations for a representative.

1958—saw legislation authorizing the formation of The Nova Scotia Hospital Insurance Commission. This legislation requires that ". . . .at least one Commissioner shall be a member in good standing in The Medical Society of Nova Scotia."

1959—January 1st, The Nova Scotia Hospital Insurance Act became operative.

The policy of Medicine with reference to Hospital Insurance had been formulated long before January 1st, 1959. Review of the files of this Committee will demonstrate that adequate and effective liaison between the Society and Government and Hospitals was developed and has been maintained. It would also be found that many of the opinions and views expressed by Medicine appear in the administrative set-up of the Plan, the Hospital Act and the regulations. The Committee on Health Insurance has continued to deal with many details since January 1st, 1959. Indications are that such experience is likely to continue in this field.

Report of Special Committee—Chairman, Dr. T. W. Gorman.

At the Annual Meeting of the Executive Committee, June 1960, discussion of para. A42 of the report of the Committee on By-laws (Dr. H. J. Devereux) lead to the following resolution:—

> "That para. A42 be considered by a special committee of the Executive. The committee to be appointed by the Chair and to bring in recommendations to the Executive on the matter. Also to clarify the terms of affiliation."

Carried.

Para. A42 reads:—

> "In my opinion (Dr. Devereux) also the time has come when the Society should take a long, hard look at its organizational set-up, something must be done to stimulate greater interest amongst the ordinary members; to have greater representation from all Branch Societies at our Annual Meetings. I would suggest that a careful study of The Ontario Medical Society could be of considerable help."

The Committee appointed was:

Dr. T. W. Gorman (Chairman)
Dr. H. J. Devereux
Dr. W. Hewat
Dr. F. J. Barton

The Chairman of the Executive had concluded that, since this report was available, it could properly be considered by this special meeting. The report was presented by Dr. Gorman who answered many questions during a comprehensive discussion.

It was moved and seconded:

> "That the report of this Special Committee (Chairman Dr. T. W. Gorman) to review the situation of The Medical Society of Nova Scotia be tabled and that copies of the report

be sent to members of Branch Societies plus a short summary of the present structure, for discussion at Branch Societies; reports of such discussions to be available to the Executive in time for the meeting February, 1961."

Carried.

The Special meeting adjourned at 5:15 p.m.

C.J.W.B.

The Canadian Arthritis and Rheumatism Society,
Nova Scotia Division,

353 Bayers Road,
Halifax, N. S.
24th August, 1960.

To the Editor:

Will you be kind enough to draw the attention of the profession in Nova Scotia, the following two general resolutions adopted by the General Council of the C.M.A. in 1960:

(1) "THAT The Canadian Medical Association express its appreciation of the work of the national medico-lay affiliates in the prevention of disability, the promotion of good health, the detection of disease, the dissemination of information to the public and the profession, the advancement of research, the provision of essential services to patients and the promotion of rehabilitative measures. The beneficent work of these societies greatly aids the medical profession in its daily work and provides for large sections of the public assistance which would otherwise be lacking and the C.M.A. desires to record its support of the volunatry fund-raising activities in their particular spheres of interest.

(2) WHEREAS representation on the National Medical Boards of the medico-lay affiliates of the Canadian Medical Association is available and operative through the interest of many individual doctors, it is observable that in many instances the presence of representatives of the medical profession is lacking at the level of their provincial and local branches, AND WHEREAS it is understood that medical representation would be welcomed by such branches of the affiliates of the C.M.A.,

THEREFORE BE IT RECOMMENDED to the Divisions that approaches be made to the provincial organizations of the affiliates, on their own behalf and on behalf of their branch medical societies, with a view to providing suitable medical representation and active participation at all levels of operation."

The Canadian Arthritis and Rheumatism Society, as a Medical affiliate of the Canadian Medical Association, wishes to express its desire to co-operate with The Medical Society of Nova Scotia and its Branches, and would be happy at any time to discuss its policy and its problems of organization and expansion with the Society or any Branch.

Yours sincerely,

JOHN F. L. WOODBURY, M.D.,
Medical Director.

SHOULD THE MEDICAL PROFESSION TAKE THE PUBLIC INTO ITS CONFIDENCE?

by

JACK GOLDING*

Halifax, N. S.

I approached this piece of writing about the medical profession with reasonable confidence. Then I began to think about it and the more I thought the less I liked the idea. It suddenly dawned on me that offering comment about highly trained professional people was a presumption, that I had all the rope required and would, indeed, hang myself before the editor could say, "Two thousand words!"

But ego is a trade mark in the writing business and I am one of the fools who will tread where angels probably wouldn't. If there is any avenue of escape or any qualification I can offer at the beginning, then it had better be made now. My offerings on the subject of the medical fraternity and its public or community relationships are sincerely meant; are expressed as they would be in a private conversation; and are merely reflections of what a man in the street feels his companions think about the medical profession.

I have no axe to grind and no nasty little barb to throw, because my personal experience with doctors has been happy. If there is any major criticism I have to offer it is basically that the medical people are so busy, or appear to be so busy, that they do not take a sufficiently aggressive attitude in advising people, not only about a current illness or physical difficulty, but about how patients should conduct themselves and their lives purely in a physical sense.

To me a doctor is the Almighty, as was the first doctor I ever encountered when I was young. I think the doctors today *should be more demanding* of their patients. They should *tell* them—not ask them or politely caution them. People like it!

About 1920 I had the biggest boil in New Brunswick on my neck and I was a kid of eight. The family doctor was a wonderful guy called Dr. G. A. B. Addy and a top surgeon to boot. He was tall and husky. He wore a frock coat and striped trousers, pince-nez, bat-wing collar and flowing cravat with a pearl stick-pin. He drove in a big car and wore a top hat. His office had all the latest magazines (not the oldest!) and there was a magnificent moosehead with 22 points in the waiting room. There was an odor of drugs and bandages that was intriguing, and I knew if I didn't cry he would give me a quarter or a piece of candy. A big grandfather clock used to boom out the quarter-hours for one had to wait a long time in those days, too!

My father had promised me a wrist watch if I were a good boy and didn't flinch when the doctor "looked after me." No one told me what lancing meant. Incidentally, a Waltham wrist watch in those days cost about $3.50 and was so big a kid would drown if he fell in a river and couldn't get it off his arm. So I kept thinking about that watch and Dr. Addy held a surgical instrument in front of me and said, "It won't hurt for more than two seconds, Jackie." Before the echo of his voice died it had hurt for two seconds and I could straighten my head. The throbbing had gone and my pain disap-

*Journalist and Radio and Television Commentator.

peared. I believed in that man as I have believed in few things or persons since for he always told me the truth and, unconsciously, as a child, it made me feel grown up and confident.

I am not sure where people go when they die, but wherever the best place is, I am positive old Doc Addy is mighty popular and respected there.

Having been brought up in a newspaper family and one that also ran a vaudeville theatre, I have been acquainted with print, publicity and opinion (freely expressed) most of my life. Thanks to my parents and their friends there has been no paucity of truth about almost anything. As a news reporter it has always irked me that doctors could win a Nobel prize for being evasive. It isn't that they should always tell what happened but that they take a superior attitude towards the public and then retire behind their mysterious curtain. The only thing left to sense is the bouquet of chloroform or an ambiguous remark. A few years in the army in a war theatre taught me that doctors were people who only made as much as their rank indicated in the pay manuals—good guys who didn't hesitate for a moment to tell a person exactly what the score was. I realize that some people or patients are pathologically incapable of being told the truth and that, in fact, it might be wrong to do so. But I think doctors today are inclined to take the easy way out and say as little as possible. Some are almost as unctuous as undertakers.

I will be among the first to admit that the reluctance of the medical profession to deal with the press is, in many instances, justified. But because some reporters are too young or irresponsible should not mean that the door is shut—as it often *is* shut! It is also partly the fault of the medical profession for not calling the principals and asking politely, or demanding in a tough manner if necessary, that the press have people handling their copy who understand or who can be made to understand. Chips usually fall on both sides of a log. But I do admit most freely to the natural fear that a medical story can be misconstrued.

Large sections of the press have gone to pieces in this modern age in pandering to advertisers. In other words, they won't say anything objective about a customer unless it is complimentary! In the same sense, I think the medical fraternity is guilty in many instances of not shouldering its responsibility. For example, let us take the use of tobacco. If medical research people know for certain that cigarette smoking is definitely harmful, then for God's sake let them come out and say so! If doctors don't make the position clear then how are laymen to know? Why worry what a big corporation thinks? Or is the corporation more important than the little people who only need to be told by their family doctor? I do not know that tobacco is seriously harmful but there has been a considerable silence among medical people except for a few. It is always a few . . . . in any walk of life.

The same applies to the use of liquor. The same applies to people who have too many children or who over-eat—any intemperance—because intemperance does not only apply to drinking.

I think the Nova Scotia medical fraternity should have a professional public relations man who knows when, where and how to launch its latest developments and explain its latest trends. It does not follow that a clever, successful doctor knows how to deal with the general public. Every man to his own business. *The closed shop of the medical fraternity is one of the last feudalisms in our society and it is considered aristocratic and arbitrary by*

the man in the street who uses his brains occasionally. Certainly there is a thin sprinkling of PR men in the medical world but not in Canada. There may be one, two or three but that's all. The doctors still like to play their cards close to their vests—when they don't need to do so, and the public continues to wonder why they are so secretive.

Let's take Nova Scotia and Halifax for example. I know that the average income each year is about $9,500 for a doctor who works pretty hard. The people think your minimum, gentlemen, is at least $25,000! They think you practically *coin* money. They think, in many instances, you get a rake-off from drug stores. I know this is not true but many people think so. It is also a fact that when you prescribe drugs you are genuinely considering the swiftest and most effective manner in which to give a patient relief and safety. That is, most doctors think so.

The man in the street, having read about investigations into drug prices, directly relates your decision about a prescription to its cost. This point is not fair to you but this is what many people think. And they think it because the medical fraternity has done nothing to dispel their imagination. Are the claims of drug companies correct? Do they truly spend millions in research? Drug prices far outweigh what doctors charge for attention and such drug costs often cripple family budgets. People look to doctors to help them in this respect. Do you realize that many, many sick people and their families do not know you give salesmen's samples to them at no cost? Do they realize when you commit them to hospital in a public ward at the Victoria General Hospital in Halifax you are shorn of any fees? No, they do not! And if they don't, then it is your fault, gentlemen, for not having your own medium to tell them publicly.

In the main, doctors are poor business men. They need the help of bond and stock salesmen, insurance salesmen, chartered accountants. It is a rare bird who is a good professional man in the medical world and a business man too. No one is degrading the high aspirations of the Hippocratic oath for it is a solemn commitment. But in this material age when our soft living inclines the average person to avoid the hard points of life, it is evident in many instances that the medical profession is selling itself short!

So is the communications business and by that phrase I mean press, radio and TV. We are too swayed by our cash customers who only want to hear the nice things about life and themselves. Life is not like that. In Britain the health plan has done much good for millions but too many people have suddenly become "ill." The doctors' waiting rooms are jammed and any self-respecting citizen who wants his pregnant wife not to wait too long (hours can be the case) merely calls a doctor on a private basis. I was in England when the socialist health plan came into effect; was part of it as an ordinary citizen and finally found out what I had to do to get the treatment one routinely receives on this side of the ocean. We do not want that system in Canada for my money—though their much less expensive drugs are important.

But if we don't want it then I suggest with respect that SOME of the doctors who are comfortable financially relegate their feudal aloofness and superiority to the nearest waste basket and come forth, tell the people as much about the profession as it is reasonable to tell, and *keep* them informed.

In the world of the medical specialist all may be serene but the public is confused. Few people realize that you medical people have boards which demand stringent qualifications for those setting themselves up as specialists.

The initials of accomplishment after your names mean something to another doctor but their meaning is seldom spelled out for the patient so he or she can fully appreciate what you have done to earn a particular honor within the fraternity of physicians and surgeons. Shouldn't the man know who has to go under the knife? Perhaps it is assumed he should accept the fact of your proficiency, but it would be a greater kindness to his morale if he knew. You may think this feeling is juvenile on the part of the patient. Possibly it is, but is there anything wrong with telling him or letting him know indirectly through normal channels of information? Ask any 25 people walking down Barrington Street what they understand by "F.R.C.S." and regard the replies with amazement!

Many thousands of people simply think "a specialist" is a name a doctor gives himself so he can raise his fees. A man can be a news, radio or TV reporter and write objective copy. If he has any media that will print his opinion then he is entitled to call himself a commentator whether he is solid, mediocre or just plain wrong. Or lousy if you like. But there is a sharp distinction between writing about what actually happened and giving one's opinion on what *did* happen.

I am not one of those people who is annoyed because a doctor makes a much better than average income—if he does so. Good luck to him! A doctor is on call around the clock. He must be extremely circumspect particularly if, like many people, he should enjoy a drink occasionally. He has to take the night off. A doctor has, probably, less privacy than most people.

The medical profession caused much quizzical comment for a couple of years because it landed with both feet on proposed legislation to allow chiropractors to govern themselves and employ diagnosis and use X-rays. Careful study of the medical presentations made their position clear, but the ordinary reader of a newspaper doesn't go into such study carefully. Why wait until such key items come strongly into public view and then land on them—and retire?

It seems evident that the medical profession should maintain a steady flow of information to the people through the mass media of newspapers, radio, TV, magazines. Tell the public more about what is going on in your professional circle. Slough off some of that aloofness, gentlemen . . . you don't have to give any secrets away. You don't have to tell anything not in the interests of the public. But don't remain apart like benign Pharisees in this age when people who pay for service one way or another have a right to know what is going on.

I said, "a right to know . . . ."

SYMPOSIUM ON OEDEMA*

PART III. A REVIEW OF THE PATHO-PHYSIOLOGY OF PULMONARY OEDEMA

ALBRO D. MacKEEN, Ph.C., M.D.**

Halifax, N. S.

Pulmonary oedema can be defined as the movements of excess water and solutes produced by abnormal hydrostatic pressure and concentration gradients across normally or abnormally permeable alveolar-capillary membranes.

A brief review of the basic physiological principles concerned in the production of pulmonary oedema is necessary. The pulmonary capillary hydrostatic pressure is not known exactly but is considered to be between 9-10 mm. Hg. as it must be less than the normal pulmonary diastolic arterial pressure (approx. 11 mm. Hg.) and greater than the pulmonary venous pressure (approx. 7 mm. Hg.). Obviously the effective peripheral resistance of the pulmonary system is low and normally plays a small part in controlling the circulation. The colloidal osmotic pressure of the blood is approximately 25 mm. Hg. which means that conditions favor retention of fluid within the pulmonary capillaries even when the negative intraplural pressure of approximately -5 mm. Hg. is taken into consideration. Therefore, circulatory arrangements are such as to keep the air passages dry, and there is a generous safety margin before frank pulmonary oedema occurs. The Bainbridge reflex also protects against oedema production in that a rising pulmonary venous pressure initiates an acceleration of cardiac contraction with more rapid removal of blood from the lungs.

TABLE I
Immediate Determinants in the Genesis of Pulmonary Edema

	Factor	Condition Promoting Edema
1.	Pulmonary Capillary Blood Pressure	Elevation
2.	Filtration Area	Increase
3.	Capillary Permeability	High Permeability
4.	Plasma Colloid Osmotic Pressure	Decrease
5.	Lymphatic Vessel Pressure	Increase
6.	Colloid Content of Alveolar or Interstitial Fluids	Elevation
7.	Interstitial Fluid Pressure	Decrease will promote Capillary Filtration

No single mechanism is responsible for all forms of pulmonary oedema. Table I lists several immediate determinants involved in the production of such oedema. They will be considered briefly and separately although they are not independent of each other.

CAPILLARY PRESSURE. Table II lists the four direct factors maintaining pulmonary capillary pressure in the intact circulation. The multiplicity of primary factors which determine pulmonary capillary pressure complicates the analysis of mechanisms in producing pulmonary oedema. Table III lists several of the known experimental procedures capable of inducing pulmonary oedema and the intermediate mechanisms capable of increasing the pulmonary capillary pressures.

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*From the Department of Medicine, Dalhousie University and the Victoria General Hospital.
**Research Fellow in Medicine, Victoria General Hospital, Halifax.

TABLE II
Direct Determinants of Pulmonary Capillary Pressure

Variable	Direction of Change	Direct Effect on Pulmonary Capillary Pressure	Effect on Pulmonary Venous Pressure
Pulmonary arteriolar bore	Constriction Dilatation	Fall Rise	Fall Rise
Pulmonary venule bore	Constriction Dilatation	Rise Fall	Fall Rise
Pulmonary artery pressure (without arteriolar bore change)	Rise Fall	Rise Fall	Rise Fall
Pulmonary venous or left atrial pressure	Rise Fall	Rise Fall	(Pulmonary venous pressure is the determining variable)

Filtration Area. To date, there have been no studies of pulmonary oedema in which the filtration area of the pulmonary vascular bed has been quantitated but it may be predicted that any nervous, chemical or physical change which alters small blood vessel tone could affect the filtration area and thus the filtration rate. This is particularly pertinent because of the general association of pulmonic congestion with oedema, even when the pulmonary venous pressures are not elevated, as in phosgene poisoning.

Membrane Permeability. Wasserman and Mayerson (19), employing dextrans of known particle size, showed that only smaller particles escaped rapidly from the blood stream while an increase in circulating blood volume led to a subsequent loss of the larger particles from the blood. These findings can be interpreted most readily by assuming that the permeability of the capillary wall is directly influenced by the degree of distention of the blood vessel.

The fact that alveolar oedema can occur with very low protein content proves that excessive permeability to protein is not required in lung oedema formation. Also, the fact that large quantities of protein are sometimes lost through the alveolar capillaries shows that those capillaries can become abmormally permeable to colloid.

The role of low oxygen tension is altering capillary permeability is one which has received a great deal of attention since 1945 when Drinker (3) stated, "It is my belief—I cannot say conviction—that simple pulmonary oedema and the more serious pulmonary exudations depend more upon alterations in the permeability of the lung capillaries than upon complicated pressures." The much quoted conclusions of Drinker, that hypoxia promotes a development of pulmonary oedema through an increase in capillary permeability, have not been substantiated. Narin[11] found no evidence whatever that oedema occurred more rapidly or was more massive when the lung was perfused with blood at 50% O_2 saturation than at full saturation, and concluded that within physiological limits hypoxia was not a factor in the genesis of

TABLE III.
Some Indirect Effects upon Pulmonary Capillary Pressure

Initiating Factor	Mediating Mechanisms	Ultimate Effect on Pulmonary Capillary Pressure
Aortic pressure elevation (Obstructive	1. Increased residual blood in left ven tricle: Increased left atrial pressure	Elevation
	2. Pressoreceptors: Heart rate reduction. Increased atrial pressure	Elevation
Increased intracranial pressure	1. Vagal stimulation: Heart rate reduction. Increased atrial pressure	Elevation
	2. Sympathetic discharge: Elevation in systemic arterial pressure. Increased left ventricular end-systolic volume	Elevation
Increased blood volume	1. Increased right heart filling: Increased pulmonary artery pressure and blood flow. Increased pulmonary venous pressure.	Elevation
Epinephrine	1. Systemic vasoconstriction	
	a. Left ventricular strain. Increased left atrial pressure.	Elevation
	b. Decreased systemic vascular bed volume. Increased filling of right heart with elevation of pulmonary artery pressure	Elevation
	c. Increase in cardiac output	Fall
	2. Reflex bradycardia: Increased atrial pressures.	Elevation
Bilateral cervical pressure	1. Laryngeal obstruction: Lowered intrathoracic pressure. Increased right heart filling and increased pulmonary artery pressure.	
	2. Asphyxia: Heart failure. Increased atrial pressures.	Elevation
	3. Interruption of normal reflex paths. a. Changes in blood distribution between greater and lesser circulation?	Unknown
	b. Vasomotor changes in lung?	Unknown
Respiratory obstruction A. Inspiratory resistance.	1. Lowered intrathoracic pressure: Increased right heart filling and increased pulmonary arterial pressure	Elevation
	2. Asphyxia: Heart failure Increased artrial pressures.	Elevation
B. Expiratory resistance	1. Elevated intrathoracic pressure: Decreased right heart filling.	Fall (temporary)
	2. Decreased right heart filling and asphyxia: Progressive heart failure. Increased atrial pressures.	Elevation (ultimate effect)
Mitral stenosis	Elevated left atrial volume and pressure	Elevation
Posture alterations. Example: Goat in the dorsal recumbent posture	Increase in hydrostatic pressure head on pulmonary veins in dependent portions of lung	Elevation (limited to levels lower than heart).

oedema. The results of Henry[8] et al indicate that an increase in protein permeability of capillaries ensues when the venous 0_2 saturation falls below 25%.

Haddy et al.[7] repeating the work of Drinker, clarified the situation by showing that the occurrence and extensiveness of the oedema was related to an elevation of pulmonary venous pressure, and the lowered cardiac output during the last quarter hour of life, which could also be used as an index of left heart failure.

PLASMA AND INTERSTITIAL FLUID OSMOTIC PRESSURE. Paine et al.[13] found that when hypoproteinemia was induced lung oedema occurred without change in heart function. A most interesting observation of Pappenheimer et al.[17] showed that a change in protein concentration produced a long delay (approx. 1 hr.) in the establishment of a new equilibrium in "iso-gravimetric" pressure.

It may be suggested that changes in colloid osmotic pressure are less critical factors in the production of pulmonary oedema than in oedema elsewhere. In the lung capillaries, the hydrostatic pressure is normally below the colloid osmotic pressure along the entire length of the vessel while in capillaries in the remainder of the body higher pressures prevail, so that small changes in colloid content may be effective in changing the direction of net water movement. This fact is responsible for the normal "dryness" of the lung. Water introduced intratracheally is absorbed into the blood rapidly; plasma protein solutions so administered are very slowly absorbed. If the colloidal osmotic pressure of the intra-alveolar fluid is sufficient to overcome that of the pulmonary capillaries—oedema results.

LYMPHATIC VESSEL AND INTERSTITIAL FLUID PRESSURES. Paine et al.[14] found that complete blockage of the large terminal lymph vessels did not cause pulmonary oedema. Many investigators have found that pulmonary lymph flow frequently increases when pulmonary oedema occurs. Therefore, complete obstruction to lymph drainage is not necessary for pulmonary oedema to occur. Since massive pulmonary oedema can occur in a few minutes, one cannot suppose that simple lymphatic obstruction is the usual initiating factor in acute oedema. The pulmonary lymph flow in odema reaches about 1 ml./min., but even so does not approach the rates of oedema fluid accumulation in the lung, therefore, the lymphatics are not capable of serving beyond a rather narrow range in protecting the lung against flooding its tissues by excessive filtration.

SOME PERTINENT ANATOMICAL AND PHYSIOLOGICAL CONSIDERATIONS. Sarnoff and Berglund[18] studied the pressure/volume characteristics in the pulmonary vascular bed and noted that there is an important stress relaxation in these structures in that the pressure necessary to maintain a given volume is less than that to produce it. This property has significance in connection with the deleterious effects of temporary high pressures on the venous side of the pulmonary bed. It may account partially for the difficult and slow reversibility of lung oedema, especially if extension of the capillary surface is itself a determinant of permeability to protein.

REGULATION OF BLOOD FLOW THROUGH THE LUNGS IN RELATION TO PULMONARY OEDEMA. Daly et al.[2] showed that when the pulmonary vascular bed is fed at constant inflow pressure, a stimulation of the upper thoracic sympathetics may reduce the lung blood flow by as much as 30% . . . invari-

ably associated with pulmonary vasoconstriction as judged by the rise in pulmonary arterial pressure and decreased outflow from the pulmonary veins.

The changes due to pH. alterations were very much greater than those induced by sympathetic nerve stimulation. The higher the pH. the lower the flow. This might suggest that chemical factors may exceed in importance the nervous ones in the control of the pulmonary vasculature.

Elevations of pulmonary artery pressure by arteriolar constriction have not been observed to cause lung oedema. In human disease pulmonary artery hypertension is not a recognizable cause of lung oedema, as in pulmonary hypertension. It may be suggested that processes regulating resistance to flow (pressure drop) through lung arterioles may be of greater importance here. A five-fold or greater increase in cardiac output and pulmonary blood flow occurs in exercise, and is accomplished in normal individuals, with rare exceptions, without acute lung oedema. The pulmonary artery pressure in diastole decreases in exercise in spite of the increase in pulmonary blood flow.

TABLE IV

Indirect Determinants of Experimental Pulmonary Edema.

I. *Primary hemodynamic alterations.*
   A. *Heart and great vessels*
      1. Ventricular obstruction: left; right
      2. Coronary occlusion
      3. Compression or occlusion of left ventricle
      4. Compression or occlusion of left atrium
      5. Valvular defects: aortic insufficiency: mitral insufficiency; mitral stenosis
      6. Occlusion of aorta and/or its branches
      7. Compression of pulmonary veins
   B. Hypervolemia
   C. Arterial hypotension: shock, hemorrhage,
   D. Embolism

II. *Alterations of the central nervous system*
   Brain lesions: compression or stimulation

III. *Alterations of the peripheral nervous system*
   A. Vagotomy
   B. Vagotomy with tracheotomy
   C. Faradic stimulation of lung root

IV. *Alterations of the respiratory system*
   A. Airway obstruction: inspiratory; expiratory
   B. Hypoxia with heart overload or failure
   C. Respiratory burns and heat
   D. Drowning
   E. Intratracheal fluids
   F. Chest wounds
   G. Blast

V. *Pharmacological effects*
   A. Vasoactive drugs: muscarine; acetycholine; neostigmine; histamine; amyl nitrite; epinephrine; pentylenetetrazole (cardiazol Metrazol) and nikethamide (Coramine); picrotoxin; nicotine
   B. Lung irritant gases; oxygen poisoning
   C. Other agents: alloxan; ammonium ion; thiourea compounds; methylene violet, methylene blue; methylsalicylate; acetic, sulfuric, and butyric ether; acetic ether and iodide solution; amyl salicylic ether; iodine and solium iodide solution; iodoacetamide; bile and bile salts; urethane; carbon monoxide; carbon dioxide; barbiturates.
   D. Metabolic effects; alkalosis; hypoglycemia

VI. *Miscellaneous*
   Hyperthermia; sensitivity phenomena; mechanical irritation of the bronchus.

Table IV lists some of the indirect determinants of pulmonary oedema which have been experimentally produced. Only a few of these factors will be briefly discussed in order to focus attention on the scope and complexity of the analysis of the patho-physiology of lung odemea.

Pulmonary Oedema Following the Administration of some Chemical Agents: Adrenaline: Korner[9] found a significant shift in blood volume from the systemic to the pulmonary vascular bed upon the administration of nor-adrenaline. He is inclined to attribute the increased volume in the lungs to a vasomotor redistribution of blood rather than to left heart failure. The studies are particularly important in shedding some light on the mechanism by which pulmonary oedema may be produced by some hypertensive agents without primary heart failure. However, Paine et al.[15] found that the left atrial pressure rose to values as high as 90 cm. H_20 terminally and concluded "that although stress against the myocardium may be of neurogenic character, the generation of pulmonary oedema is due to a cardiogenic mechanism." Thus the controversy concerning whether the pulmonary venous hypertension is due to (a) a redistribution of the blood between the systemic and pulmonary beds or (b) to failure of the left ventricle to deliver enough blood per contraction so that the pulmonary venous pressure can be kept at normal limits, is partly and perhaps entirely a semantic one.

Histamine: It has not been possible to produce lung oedema by direct injections of histamine into the pulmonary circulation so it seems unlikely that the lung oedema occasionally reported after long term injections of massive doses of histamine is due to direct actions on the pulmonary vascular bed. The information which exists today does not shed any more light on this problem.

Lung Irritants: The haemodynamics in pulmonary irritant poisoning show a consistent decline in right ventricular pressure associated with a rise in pulmonary circulation time, without evidence of right ventricular failure. There was no rise in the pulmonary artery or left atrial pressures, therefore the pulmonary vascular congestion regularly observed could only be brought about by either pulmonary venous constriction and/or a decline in the elasticity of the capillary wall. There are at present no data to indicate as to which applies.

Pulmonary Oedema Associated with Physical Changes: Hypo-Volaemia: Moon and Morgan[10] reported numerous instances of pulmonary oedema associated with traumatic shock in man. Eaton (4) found a decreased cardiac output and fall in the systemic arterial, venous and pulmonary artery pressures. The early effect of acute haemmorrhage is a fall in the left atrial pressure but Paige[12] reported late rises in the central venous pressure in shock, indicating terminal heart failure.

Hypervolaemia: Numerous investigators have found that rapid intravenous injections of fluids can induce pulmonary oedema with an increased pulmonary blood volume, the left atrial pressure raised more than the right and an increased pulmonary artery wedge pressure. Gibbon[5] showed that the amount of plasma necessary to induce pulmonary oedema was less after removing parts of the lungs, indicating that the extent of the lung bed is a critical factor in determining the vascular pressure rise in hypervolaemia. Hy-

poxia increases the degree of oedema produced by causing a reduction of cardiac output with a compensatory systemic vaso-constriction shifting a larger fraction of the blood volume into the pulmonary vascular bed, thus raising the pressure within it. Nor-adrenaline also decreases the dose level of infusion necessary to cause pulmonary oedema. Since there is no evidence of primary heart failure, there is some justification for assuming that primary pulmonary congestion occurs. However, it must be pointed out that the congestion occurs because the left ventricle does not deliver sufficient blood per beat to keep the left atrial pressure at normal levels.

Pulmonary Oedema Associated with Increased Intercranial Pressure and Brain Lesions: Paine et al.[13] found upon study of 686 cases of autopsy material that more than 75% of the patients with neural disease exhibiting pulmonary oedema at necropsy had concomitant heart disease and/or hypertension. They point out that a previously damaged or overloaded heart is more susceptible to the development of frank failure with small increments in loading, and interpret their data as supporting evidence for an essentially cardiac origin of clinical "neurogenic" lung oedema. Campbell et al.[1] found that increased C.S.F. pressures caused increased pulmonary venous pressure associated with a bradycardia which could be abolished by atropine. The latter drug thus protects against lung oedema. Bilateral cervical vagotomy abolishes pulmonary oedema induced by increased C.S.F. pressure. Bradycardia from vagal stimulation is associated with an elevation of pulmonary venous pressure.

Intra-cisternal injection of thrombin and fibrinogen induces lung oedema associated with an elevation of both pulmonary and systemic arterial and venous pressures. Bilateral cervical vagotomy does not protect against the elevation of the pulmonary venous pressure. However, extensive elimination of sympathetic innervation has a profound effect in relieving the elevated pulmonary venous pressure. According to Sarnoff, "The use of the term 'Neurogenic'pulmonary oedema has . . . . . ceased to be useful means of explicit communication." He favors the term "Neurohemodynamic," which he defines as "a state wherein an increase in the rate of transfer of fluid from pulmonary capillary to the extravascular space of the lung is brought about either directly or indirectly by nerve impulses." He suggests that the shift of blood from periphery to lung need not be due entirely to left ventricular failure, but may be dependent also "in part upon the fact that a vascular bed of high constrictor potential (systemic) can shift blood into an area of low constrictor potential (pulmonary) and thereby elevate the pressure in the latter. It may be argued that the elevation of pulmonary vascular pressures after fibrin injection was produced by pulmonary vasoconstriction. Against this is (1) an increase in pulmonary vascular resistence does not occur and that (2) in experiments in which complete pulmonary denervation prior to fibrin injection was carried out did not prevent subsequent vascular hypertension.

Vagotomy Pulmonary Oedema: At the present time it is apparent that the major factor in vagotomy lung oedema is airway obstruction, leading to consequences which can be in large part reproduced by artificially inspiratory airway obstruction or resistance.

Left Ventricular Failure: Numerous studies have approached the problem experimentally and the results may be summarized as indicating that whenever left ventricular failure occurs and left atrial and pulmonary venous pressures rise, pulmonary oedema is promoted.

Bradycardia: It is of interest that extreme bradycardia without other obvious disturbance can be followed by lung oedema, as occurs in man during sudden episodes of heart block. This can be produced experimentally by stimulation of the peripheral end of the cut vagus nerve.

Resistance Breathing: Haddy et al.[7] found that inspiratory airway resistance did not result in significant lung oedema if the pulmonary venous pressure did not rise above 13 mm. Hg. In the cases in which massive lung oedema occurred there was no instance of a pulmonary vein pressure less than 15.5 mm. Hg. and the average was above 20 mm. Hg. The values for cardiac output were low. They interpreted the elevated pulmonary venous pressures with low output to be evidence of progressive left ventricular failure. Also with expiratory airway resistance these authors found a comparable correlation between pulmonary venous pressure level and the occurrence of severe lung oedema.

A major theme in some clinical writings on the treatment of lung oedema has dealt with positive pressure breathing, in the belief that pressure breathing in essence raises the alveolar and tissue pressures in the lung and thus promotes reabsorption of alveolar and interstitual fluid. If ambient atmospheric pressure is taken as the point of reference it is obviously true that the above-mentioned pressures are in fact raised. However, if the actual intrapleural pressure is considered as the point of reference, as it should be, the fallacy of the reasoning becomes apparent, because the intrapleural pressure rises with the intrapulmonic. Since the heart is subjected to intrapleural pressure, in reality the first effect of raised intrathoracic pressure due to pressure breathing is a decline in venous return to the right side of the heart. The right ventricle puts out less blood because of lesser filling and the pulmonary vascular changes are secondary.

Summary

This paper has attempted to review the many factors operating in the production of pulmonary oedema. The author regrets that the present state of knowledge in this field does not allow either simplification or dogmatism.

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A Study of the Association of Group A Streptococci with Acute Glomerulonephritis. Bernstein, S. H., and Stillerman, M., Ann. Int. Med. 52: 1026, (May) 1960.

In this study, each of 51 patients with acute glomerulonephritis had either bacteriologic and/or serologic evidence of preceding streptococcal infection. The demonstration of a variety of group A streptococci in the throat cultures of the patients and their familial contacts suggests that many strains are capable of precipitating nephritis in man. The streptococcal antibody that most regularly correlated with the occurrence of acute glomerulonephritis was found to be antistreptolysin O. Three of the patients had direct or indirect evidence of recurrence of exacerbation of nephritis following new streptococcal infection. None of the 51 patients had evidence of chronic renal disease at the time of writing, but further observation is planned to assess further the relationship between acute post-streptococcal glomerulonephritis and latent or chronic nephritis.

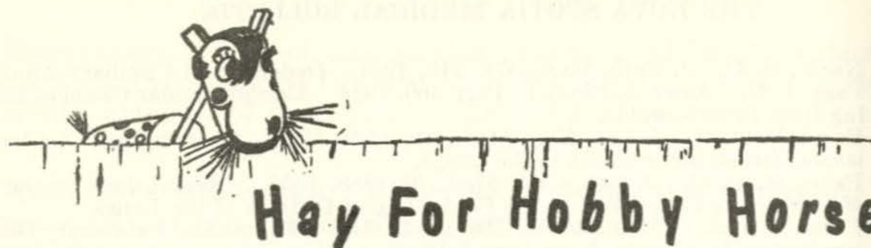
S.J.S.

"Although man's greatest distinguishing characteristic is his ability to indulge in and communicate rational thought, this is falling far behind his collective ability to gather knowledge. Largely because of this, it is increasingly difficult for the scientist to range broadly over science and the humanities, an activity which is necessary if wisdom is to keep pace with mere knowledge and know-how—and the wisdom is essential if humanity is to be guided rather than led astray by science."

J. Ralph Audy, M.D.,
in "Conference" August, 1960.

The Academy of General Practice requirements have done a lot to stimulate attendance at meetings.

W. Albert Sullivan, Jr., Director of the Department of Continuation Medical Education, University of Minnesota., in "Conference" August, 1960.



THE INSCRUTABLE PROTAGONISTS

My fellow scribbler, Spiral E. Quiet, in his editorial in the August issue, struck us in a sensitive spot when he said "out of a total membership of nearly six hundred doctors a mere handful of thirty or forty at the most saw fit to attend any of the vitally important business sessions of the Society." Elsewhere in this issue some possible causes of this state of affairs is examined briefly. My title, the Inscrutable Protagonists, is an attempt to capture the point of view of one working for the membership-at-large, without access to the opinions and attitudes of the majority. Will you consider for a moment the problems created at the epicenter by inadequate and infrequent communication with those at the periphery? The rank and file of the membership of The Medical Society of Nova Scotia, not currently holding executive or committee jobs, are limited to three principal lines of communication; through the branch society member on the Executive, directly at the annual meeting or intermittently by personal contact or through the columns of the Bulletin. Those concerned with the improvement of intra-mural professional communication recognize that these routes are impermanent, infrequent and inadequately used. Even now, ways and means to correct these defects in communication are being explored.

Even at the periphery, that indispensible lieutenant of organized medicine, the branch society executive member, may have the same feeling of frustration if the members of his branch attend poorly or are indifferent to Society problems. My friend, Pinkeye Smythe, complains that I love sixty-four dollar words so let me illustrate with a story. A revivalist preacher was addressing a camp meeting in the South when in a burst of fervor he cried, "Them as is transformed by the Power can know the unknowable, do the undo-able and unscrew the inscrutable." Those at the centre need the power of the transformed because in order to do our jobs we must "unscrew the inscrutable." We need to know what the membership-at-large think, want and would do in particular situations. If you were churlish you might say, "Why should we communicate? We are busy with the practice of medicine. You armchair physicians can muddle along with your nit-picking little schemes but don't involve us." Now, here is the rub. You, master physician, ministering to the populace of Sylvan Glade are a protagonist, who takes a leading part in the drama; you are an active participant or leader and, it is a case of "whether or no." The fact of being a physician involves you totally even if you don't lift a finger to shape the future of medicine.

The area where the work of organized medicine is being done was referred to above as the epicenter. The word is a happy choice referring, as it does, to the earth's surface directly above the focus of an earthquake or hurricane. (Imagine what Jim Tallgrass or Benge could do with that analogy). Those of us trying to do our bit are like the cabin boy in a hurricane

trying to wake the sleeping master. "Cap'n, Cap'n, wake up! wake up! It's your ship. What do *you* want me to do?" If you refuse to be roused you can hardly quarrel about the course we steer in your absence. There are a number of earnest, competent, respectable men on the bridge of organized medicine in this developing storm who are most anxious to do their jobs *responsive to the will of the membership*, when that will is known. (Freddy Branmill hired me on to carry ice-water and empty the ashtrays at the Executive meetings so I know whereof I speak). Take a minute and think of some of them. My colleague Lou Sheeves trying to anticipate the post-graduate needs or desires of the silent multitude; my hard-fisted boss, Sham Sane, anxious to make the Bulletin serve the entire membership; that indefatigable champion, Ron Dice to whose skillful leadership the Society owes so much or Efmuree Fader who has long since earned an O.M. if we had one to bestow and C. Jay Doublubee whose contribution is a significant part of every contribution made to organized medicine in this area. These are but a few of your servants and in naming them I intend to pay my respects to many others like them. Whatever these men feel as they go about their duties, they do not feel like autocrats greedily reaching out for more and more power.

The pity of it all is that most of our difficulties would evaporate if we sat down together in mutual confidence and talked things over. Dave Archery and I see things from different eyes but if you locked good fellows like Angie Dickinson, Dave and I in a cabin for a week-end, with lots of food and drink, we would come to a meeting of the minds to everyone's complete satisfaction. But when we don't know the other fellow's point of view we are apt to deal in ill-conceived generalizations and invidious labels that poison our relationships. Here is an example. A few months back we were busy appointing a board of trustees for the Fund for the Comfort of True Blue Physicians. Someone said that nominations should be limited to duly-qualified physicians who get up at night. Having both an infant son and a large prostate I am a shoo-in for this appointment but I wonder why an implied criticism was laid on some of our membership. It is hard when one's ability is brought into question but no physician's loyalty can be impugned *without just cause*. You may well say that Peter Pedd, peering out from behind his retorts, is out of touch or has forgotten what a true blue physician needs to keep him comfortable. But you do not have the right to suggest that old Peter has sold his soul to the Devil (as determined by the method of remuneration) because he has chosen to devote his life to a study of the phospho-lecithin content of anal tags instead of the active practice of medicine.

It is hard for an amiable and gentle fellow like myself to chide his betters but this Colonel Blimp-ish twaddle about "no man serving two masters" is too dangerous to our cause to let pass by in silence.

Yours for jolly comaraderie,

Brother Timothy

PERSONAL INTEREST NOTES

In the July, 1960 issue of The Nova Scotia Medical Bulletin (Page 228) there is listed the composition of the Nova Scotia and the Saskatchewan Legislatures, by profession. Since we believe a very definite pattern, of importance to the medical profession as a whole, is emerging from these comparative lists, we include the results of the Quebec provincial election, which took place on June 22, 1960.

COMPOSITION OF QUEBEC LEGISLATIVE ASSEMBLY
(BY PROFESSION)

	Liberal	Union National	Independent
Accountant	4	2	
Agent			1
Barrister	14	9	
Brakeman		1	
Carpenter	1		
Chief Clerk		1	
Druggist		1	
Electrician (Master)		1	
Engineer		1	
Farmer	3	9	
Forestry Engineer	1		
Funeral Director		1	
Garage Operator	1		
Insurance Agent	1		
Insurance Broker		2	
Jeweler		1	
Journalist	2		
Manufacturer	5	4	
Manufacturer's Agent	1		
Mayor	1		
Merchant	4	7	
Notary	2		
Physician	6	3	
Promoter	1		
Real Estate Agent	1		
Salesman	1		
Underwriter	1		
Writer and Business Man	1		
	51	43	1

Antigonish-Guysborough Medical Society

Though they deny they are a very "social minded" group, the summer has been passed in a very successful (?) sailing and water-skiing season.

Halifax Medical Society

September 20, 1960—More than 200 representatives of hospitals in Nova Scotia and delegates from Prince Edward Island hospitals attended a two-day annual institute for hospital personnel in Halifax. The Convention dealt with hospital administration, staffing, and accounting. Discussions included medical assessment of claims, drug utilization, operating room safety, and

hospital infections. Hospital Insurance Commission personnel also attended, and Health Minister, R. A. Donahue officially opened the institute.

Dr. Franklyn H. Hicks (Dalhousie Class of 1951) presently located in Vienna, Austria, recently visited his brother, Henry D. Hicks, Halifax.

Valley Medical Society

Dr. J. P. McGrath of Kentville recently returned from a very successful salmon fishing trip to Labrador. He was accompanied on this trip by Dr. Ted Sieniewicz, Halifax, Dr. James Sieniewicz, Montreal, and Dr. Ralph Kahle, New York.

Western Nova Scotia Medical Society

Dr. Anthony Scott, Yarmouth, recently visited his family in Ireland.

Nova Scotia Division of The Canadian Anaesthetists Society

The Nova Scotia Division of The Canadian Anaesthetists Society is preparing to participate in an active programme which will be enjoyed by all members. Many members took part in the Second World Congress of Anaesthesiologists, held in Toronto (September 4-10, 1960) which was attended by many internationally known anaesthetists, one of whom visited Halifax in the latter part of September as a guest speaker.

The post-graduate refresher course in anaesthesia (September 12-19, 1960) provided a stimulating programme for those doctors in the Province whose work brings them into contact with anaesthetic problems.

The Nova Scotia Division of The Canadian Anaesthetists Society has elected Drs. C. H. L. Baker, Halifax, Chairman, and I. E. Purkis, Secretary-Treasurer for the year 1960-61.

Dr. Allan A. Drysdale, has returned to Halifax, where he has accepted the appointment of Fellow in Anaesthesia at the Victoria General Hospital.

University

(Editor's Note: Included is a complete list of the accepted first year medical students at the local university, so the profession may know the origin of their conferes).

Births

To Dr. and Mrs. E. H. Anthony (nee Joan Cook), a daughter, Mary Irene, Halifax Infirmary, September 2, 1960.

To Dr. and Mrs. T. W. Gorman, their 5th child, 1st. son, St. Martha's Hospital, Antigonish, August 23, 1960.

To Dr. and Mrs. J. J. Oliver Hunter, South Ohio, a daughter, August 7, 1960.

To Dr. and Mrs. Ivan Jurgens, a son, Philip William, Grace Maternity Hospital, August 27, 1960.

To Dr. and Mrs. Charles J. MacDonald, a daughter, Kathleen Mary, August 29, 1960, at the Halifax Infirmary.

To Dr. and Mrs. E. L. MacIntosh (nee Shirley MacDonald, R.N.), North Sydney, a son, Peter Stuart, Sydney City Hospital, August 16, 1960.

Marriages

Dr. Dennis W. Johnston, a Dalhousie Medical School Graduate, and Miss Lalia Angela Dauphinee, a Dalhousie Science Graduate, and a Fourth Year Medical Student, were married September 3, 1960 at the United Baptist Church in Dartmouth, N. S. Dr. Johnston is presently doing post-graduate study in Obstetrics and Gynaecology.

Congratulations

To Dr. and Mrs. E. P. Nonamaker, Halifax, on their daughter's receiving the competitive Ifan Williams Scholarship in pianoforte, at the Maritime Conservatory of Music.

Coming Meetings

November 7, 1960—Annual Meeting of The Nova Scotia Society of Ophthalmology and Otolaryngology, Halifax.

November 7-10, 1960—34th Annual Dalhousie Refresher Course, Halifax, N. S. Guest speakers will include Dr. D. G. Cameron, Professor of Mediine, McGill University, Dr. R. M. Janes, Professor Emeritus of Surgery, University of Toronto, and Dr. F. B. Carter, Professor of Obstetrics and Gynaecology, Duke University. The John Stewart Memorial lecturer: Dr. D. F. Cappell, Professor of Pathology, University of Glasgow, Scotland.

November 17-19, 1960—International Symposium on "The Extrapyramidal System and Neuroleptics"—Department of Psychiatry, University of Montreal, P. Q.

November 30—December 3, 1960—Joint Annual Meeting of the Canadian Heart Association and National Heart Foundation of Canada—Royal York Hotel, Toronto, Ontario.

DALHOUSIE UNIVERSITY - FACULTY OF MEDICINE

FIRST YEAR MEDICINE 1960-61

Acker, John Christopher	5 Tupper Grove, Halifax, N. S.
Ali, Muntaz	44 Victoria Road, Halifax, N. S. (B. W. I.)
Anderson, Kenneth	24 Dunfield St., St. John's, Nfld.
Archambault, John Louis	30 Pleasant St., Madawaska, Maine.
Barry, Isabel Rita	129 Main St., Curling, Nfld.
Beazley, Ronald William	94 King St., Dartmouth, S. S.
Berens, Sanford Victor	135 Eastern Parkway, Brooklyn, N. Y.
Blair, R. Douglas Gordon	3205 W. 24th St., Vancover, B. C.
Borden, Lester Lewis	11 Parkside Drive, Great Neck, N. Y.
Brown, Charles Arthur	25 Spear St., Melrose, Mass.
Bugden, Claude	Norris Point, Bonne Bay, Nfld.
Burke, Francis Adolphus	181 Elm Ave., Charlottetown, P. E. I.
Burns, Gerald Ross	81 South Park St., Halifax, N. S.
Campbell, Clarence Murdock	81 Longworth Ave., Charlottetown, P. E. I.
Chan, Emerson Wing-Tim	6 Lily St., Tai Hang, Hong Kong.
Craig, Ronald Thomas	249 Williams St., Lancaster, N. B.
Darbasie, Merle Cecile	14 Charlotte St., Princestown, Trinidad, B. W. I.
Douglas, George David	200 Victoria St., Amherst, N. S.

Edwards, Mohammed Avard	Bridgetown, N. S.
Fattel, Lewis Howard	8300 Hudson Blvd., North Bergen, N. J.
Gaum, Winston Elliot	18 Howe St., Sydney, N. S.
Gillis, Francis Gerard	156 Catherine St., S., Hamilton, Ont.
Hammerling, Dorothy Judith	417 Quinpool Road, Halifax, N. S.
Hansen, Niels Henry	8 North River Road, Charlottetown, P. E. I.
Harris, Lawrence Kenneth	11 Broadman Parkway, Jersey City, N. J.
Hawk, Hubert Edmund	218 S. Seminole Trail, Mentor, Ohio.
Hogan, Martin William	15 Beaumont Ave., Grand Falls, Nfld.
Jamieson, W. R. Eric	279 Munro St., Bathurst, N. B.
Jefferson, John Chalmers	194 Victoria St. East, Amherst, N. S.
Kinley, Richard Hummer	371 Spring Garden Road, Halifax, N. S.
Lantz, Joseph Brodie	Keppoch, P. E. I.
Lea, Robert Henry	62 Great George St., Charlottetown, P. E. I.
Loebenberg, Ralph	701 West 180th, New York 33, N. Y.
Macaulay, Lynda Christine	35 Fraser St., Sydney Mines, N. S.
Macdonald, Oonah Brigid	"Winwick", Marlborough Woods, Halifax, N. S.
MacKay, William Allan	Clinton, P. E. I.
MacKenzie, Colin Albert	Havil's Trailer Park, Lakeside, Hfx. Co., N. S.
MacKenzie, Kenneth Spurgeon	277 Richmond St., Charlottetown, P. E. I.
McNeill, Laurie Keith	99 Pleasant St., Dartmouth, N. S.
Madsen, John Anker	1 Pleasant St., Tide Head, N. B.
Maharaj, Deodath Thacoorpersad	Sewalla St., Caroni, Trinidad, B. W. I.
Maharaj, Gunness Ramnanan	7A Sutton St., San Fernando, Trinidad, B. W. I.
Martin, Robert Henry	29A Canada Road, Edmunston, N. B.
Measham, Anthony Raymond	Apt. 10, 146 University Ave., Halifax, N. S.
Mockler, Gordon Raymond	Minto, N. B.
Morrisey, J. Thomas	41 Pugsley St., Saint John, N. B.
Paraigh, Kishor	2 George St., Sangre Grande, Trinidad, B. W. I.
Price, Carman Scott	Hant's Harbour, Trinity Bay, Nfld.
Robb, Kenneth Ian	Hampton, N. B.
Rosenberg, Edwin Michael	70-44 Harrow St., Forest Hills 75, N. Y.
Ross, Robert Alexander	44 Dominion St., Truro, N. S.
Schwartz, Daniel J.	990 President St., Brooklyn 25, N. Y.
Schwartzberg, Stuart Gerald	1 Weigt Court, Great Neck, N. Y.
Shaw, Mervin Glenn	20 Cedar St., Halifax, N. S.
Shortt, James Dawson	120 48th Ave., Lachine, Quebec.
Sim, Franklin Hindson	153 Hinchey Ave., New Waterford, N. S.
Strober, Morton	64-41 Saunders St., Rego Park 74, N. Y.
Tiller, William Douglas	52 Cornwall Cres., St. John's, Nfld.
Trueman, Douglas Hugh MacMillan	Rothesay, N. B.
Vallet, Herbert Lawrence	332B 36th St., Edgemere 91, L. I., N. Y.
Walker, John David	40 East Valley Road, Cornerbrook, Nfld.
Woolfrey, Ivan Roy	272 Main St., Lewisporte, Nfld.
Young, Michael Kwong-Kwing	23 Berwick St., 1st. Floor, Kowloon, Hong Kong.

SOME PRACTICAL ASPECTS OF THE SMOKING-CANCER PROBLEM

ERNEST L. WYNDER, M.D. AND DIETRICH HOFFMANN, Ph.D.

New England Journal of Medicine, March 17, 1960

The most effective way to alleviate the smoking-cancer problem would be to stop smoking or reduce it to a minimum. Practical measures for reducing the smoke condensate per cigarette are: the use of effective filters, less tobacco per cigarette, tobacco selection and highly porous cigarette paper.

The majority of those who have investigated the epidemiology of lung cancer are in agrement that smoking, particularly of cigarettes, represents one of the causes of cancer of the lung. Several health authorities have publicly supported this view These include the United States Surgeon General, Leroy Burney, the Director of the National Cancer Institute, John Heller, the American Cancer Society, the Health Commissioner of the State of New York, Herman Hilleboe, and the public-health services of Great Britain and the Netherlands. It is no longer an argument whether smoking affects the development of lung cancer, but rather a question of how the risk of the smoker can be avoided or reduced. The present report is designed to provide some practical answers to this question.

Previous Data

It is an accepted principle in carcinogenesis that the greater the exposure to a carcinogen, the greater the risk of cancer. This has also been established for tobacco smoke. Retrospective as well as prospective studies have shown that the risk of lung cancer rises with the number of cigarettes smoked. The Hammond and Horn report in 1958 showed that the non-smoker's incidence of lung cancer is 3.4 per 100,000 per year, and that of a person smoking half to one package a day is 59.3; those smoking between one and two packages have a risk of 143.9; and those smoking more than two packages 217.3. The importance of smoke condensate yield has recently been demonstrated again in butt-length studies. One study has shown that the average butt length of the British smoker is 18 mm. as compared to 30 mm. for the American smoker. This difference may account for the higher rate of lung cancer in England.

The amount of smoke condensate that comes into contact with the lung also depends upon the degree to which the smoker inhales. A majority of the published studies indicate that patients with lung cancer tend to inhale more than the control population.

The available studies indicate that a reduction in the yield of smoke condensate of a cigarette and a reduction in the amount that comes in contact with the lung will be followed by a reduction of the risk of lung cancer. The purpose of the present investigation is to determine how these ends can best be achieved and what progress has already been made in this field.

Methods

We determined the amount of smoke condensate of the ten leading American cigarette brands. The results appear in the table. In a special study we changed the frequency of the puff to two and three times per minute and found that such a change increases the yield of smoke condensate. In another

experiment we compared the quality of smoke condensate collected from the first 30 mm. of an 85 mm. cigarette to quantity from the second 30 mm. of such a cigarette. The second half of the cigarette contained 43±2.2 per cent more smoke condensate than the first half.

We also studied the ultraviolet fluorescence of inhaled and noninhaled cigarette smoke to determine how much of the fluorescent material is absorbed upon inhalation. These studies show that long term smokers absorb 80 to 95 per cent of the condensate upon deep inhalation.

AMOUNT OF SMOKE CONDENSATE CONTAINED IN THE LEADING BRANDS OF AMERICAN CIGARETTES

Brand	National Position by Sales, 1959	Type	Size	Smoke Condensate per Cigarette	Nicotine per Cigarette
			mm.	mg.	mg.
Chesterfield	6	Plain	85	39.8±2.0	2.66±0.14
Pall Mall	2	Plain	85	35.1±1.8	2.42±0.12
Camel	1	Plain	70	30.2±1.5	2.04±0.10
Lucky Strike	4	Plain	70	28.6±1.4	1.87±0.10
Salem	7	Filter	85	26.0±1.3	1.86±0.10
Winston	3	Filter	85	23.0±1.2	1.70±0.09
Viceroy	9	Filter	85	21.4±1.1	1.29±0.07
L & M	8	Filter	85	21.3±1.1	1.37±0.07
Marlboro	10	Filter	85	20.3±1.1	1.32±0.07
Kent	5	Filter	85	17.7±0.9	1.04±0.06

To compare the benzo(a)pyrene content of the smoke condensate of the two leading American non-filter and filter cigarettes, chemical determinations of this, the most potent carcinogenic compound so far identified in tobacco-smoke condensate, were made with the use of a method previously reported. The higher the smoke condensate of a given cigarette, the greater the exposure of the smoker to polycyclic hydrocarbons.

DISCUSSION

For some years our group has been concerned with the marked increase in lung cancer and the related role of cigarette smoking. In 1940 the number of deaths from lung cancer in the United States was 5,353 for males and 1,626 for females. In 1950 14,922 deaths from lung cancer occurred in males and 3,391 such deaths were reported for females; the figures for 1957 are 26,287 and 4,489 respectively. The most effective way to alleviate the problem would be to stop smoking or at least to keep it to a minimum. However, it seems difficult to educate the public effectively in this respect.

The following measures that should lead toward reducing the risk of cancer of the respiratory tract among smokers are suggested: moderation of smoking for those who cannot give up the habit; use of filter cigarettes with the lowest yield of smoke condensate; avoidance of smoking the cigarette to the butt since there is significantly more smoke condensate from the latter part of the cigarette; and not inhaling deeply since such a practice leads to much greater absorption of smoke condensate by the lungs.

The benzo(a)pyrene content of various cigarette-smoke condensates is similar when judged on a gram-for-gram basis. Per cigarette, however, it increases together with an increase in the amount of smoke condensate. Thus, the user of a cigarette with a high yield of smoke condensate will be exposed to more benzo(a)pyrene than one smoking a cigarette with a lower yield.

Filter cigarettes tend to diminish symptoms, especially that of cough, often found to be associated with smoking.

Further research must be carried out in an attempt to reduce carcinogens and co-carcinogens from tobacco-smoke condensate.

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55 SPRING GARDEN ROAD

INFECTIOUS DISEASES—NOVA SCOTIA
Reported Summary for the Month of July, 1960

Diseases	NOVA SCOTIA 1960 C	NOVA SCOTIA 1960 D	NOVA SCOTIA 1959 C	NOVA SCOTIA 1959 D	CANADA 1960 C	CANADA 1959 C
Brucellosis (Undulant fever) (044)	0	0	0	0	24	10
Diarrhoea of newborn, epidemic (764)	0	0	0	0	4	4
Diphtheria (055)	0	0	0	0	1	0
Dysentery: (a) Amoebic (046)	0	0	0	0	0	0
(b) Bacillary (045)	0	0	0	0	157	34
(c) Unspecified (048)	0	0	0	0	62	21
Encephalitis, infectious (082.0)	0	0	0	0	2	4
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	137	85
Hepatitis, infectious (including serum hepatitis) (092, N998.5)	36	0	4	1	249	189
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	165	16
Meningococcal infections (057)	0	0	0	0	11	7
Pemphigus neonatorum (impetigo of the newborn) (766)	0	0	0	0	0	5
Pertussis (Whooping Cough) (056)	23	0	3	0	357	289
Poliomyelitis, paralytic (080.0, 080.1)	1	0	0	0	90	59
Scarlet Fever & Streptococcal Sore Throat (050, 051)	195	0	101	0	748	792
Tuberculosis (a) Pulmonary (001, 002)	15	1	18	2	518	396
(b) Other and unspecified (003-019)	2	0	3	3	68	98
Typhoid and Paratyphoid Fever (040, 041)	0	0	1	1	23	29
Venereal diseases (a) Gonorrhoea — Ophthalmia neonatorum (033)	0	0	0	0	0	0
All other forms (030-032, 034)	25	0	44	0	1439	1022
(b) Syphilis — Acquired—primary (021.0, 021.1)	0	0	0	0	0	0
— secondary (021.2, 021.3)	0	0	1	0	0	0
— latent (028)	2	0	1	0	0	0
— tertiary — cardiovascular (023)	0	0	0	0	0	0
— ,, — neurosyphilis (024, 026)	1	0	0	0	0	0
— ,, — other (027)	0	0	0	0	0	0
Prenatal—congenital (020)	0	0	0	0	0	0
Other and unspecified (029)	3	0	0	0	181*	173*
(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
N.S.U.	1	0	3	0	0	0

C — Cases D — Deaths

*Not broken down

C.D.C. 2