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The NOVA SCOTIA MEDICAL BULLETIN

EDITORIAL

ON MEDICAL SERVICE

The term Medical Services Insurance may soon be only a forgotten phrase, lost in the dusty archives of Organized Medicine, if the expressed desire of an aggressive segment of the Canadian people comes to fulfillment, as indeed it might, and in anticipation of which this Medical Society could better be absorbed in defining it's work load, it's wages, it's hours and working conditions, it's fringe benefits, it's bargaining, grievance and strike procedures.

Those of you who have observed the drive of Socialism and Labor to control medical practise will realize that many adult children, when they are ill, want the tender loving care of their cradle days, with the same delightful irresponsibility. Indeed this is now demanded as one of the Canadian 'Rights'. Canadians, in truth, have a 'right' to nothing except fresh air and water, and the opportunity, won for them by their ancestors under a system of free enterprise, to seek food, shelter, happiness, health and security. They have the opportunity, also to insure themselves against various disasters, including sickness. It is reasonable, therefore, for free men to think that a wise and well disposed Government might help the poor and destitute to pay such insurance premiums as are beyond their means. But the Socialists despise a 'means test' and insist on endowing poverty, not with self respect, but arrogance.

No civilization can long survive if it developes it's society at the level of it's weaklings, however pitiful they may be, or if it plans it's economy to make inefficiency and failure an honorable estate to be elevated to the status of an independent, self-respecting way of life, enjoying full and haughty participation in complete social security without production or responsibility and at the expense of a dwindling group of willing, capable and efficient citizens.

Socialism and Labor want and expect a salaried medical profession, in group practise, complete with old fashioned personal interest and intimate family-doctor relationship. This, I think, is the finest left-handed, crooked-nosed compliment ever paid to the medical profession, for it implies that we are above the selfish drives that mark the organized effort of other groups and are too noble to resort to legal and recognized Union practise to gain our ends, and would never slow down or walk out at a time nicely calculated to hurt the public most and serve our own cause best!

I share their faith only because I know that if they get power they can enslave, by legislation, any group they wish, for a time.

To my mind the most efficient and the best regulated medical care is that in effect where the doctor and the patient accept a mutual responsibility,—

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

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* Deceased Sept. 19, 1961.

the doctor to see that the patient gets the best medical care available in his area,—the patient to see that the doctor is adequately paid for the services rendered. This ensures the maintenance of balance between good service and over service, between reasonable need and petulant demand. That the patient may wish, through insurance, to be reimbursed in part, in full, or even in profit for what he has paid out may annoy the doctor with paper work, but is otherwise none of his business.

Such a system as this is presently in operation on a national scale in one Commonwealth country, and it works well there, as it will work wherever there is mutual good-will and respect for the free enterprise system, and belief in personal freedom. Where that respect and belief is lacking, Communism, with it's discipline, not Socialism, with it's extravagance, will in the end, be the only effective alternative.

J.W.R.

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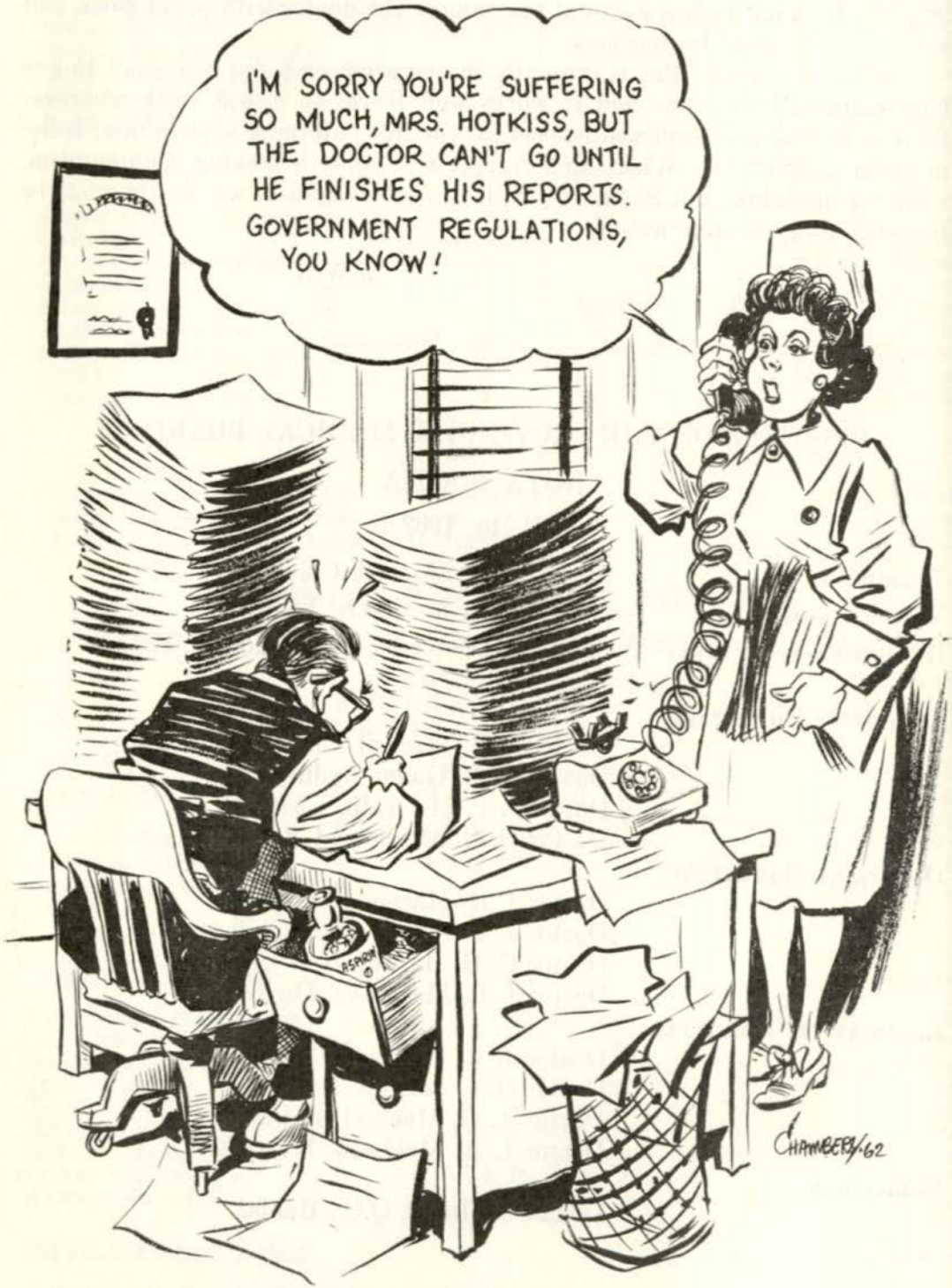

UNCLE OTTAWA FEELS NO PAIN

Transactions

of the

2ND REGULAR MEETING OF THE EXECUTIVE COMMITTEE, 1961-1962

SATURDAY, DECEMBER 2ND, 1961 NOVA SCOTIAN HOTEL, HALIFAX, N. S.

The Chairman, Dr. L. C. Steeves called the meeting to order at 9.40 a.m.

Present were:

PRESIDENT:	Dr. R. F. Ross
PRESIDENT-ELECT:	Dr. D. F. Macdonald
CHAIRMAN, EXECUTIVE:	Dr. L. C. Steeves
EXECUTIVE SECRETARY:	Dr. C. J. W. Beckwith

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PICTOU	Dr. M. F. Fitzgerald
VALLEY:	Dr. D. MacD. Archibald
WESTERN COUNTIES:	Dr. C. K. Fuller

Observers:

Chairman, Public Relations Committee:—Dr. S. C. Robinson
Chairman, Medical Economics Committee:—Dr. H. E. Christie

The Chairman explained that the rather long agenda resulted from the interval since the first regular meeting on June 14th, 1961. The preparation of the brief to the Royal Commission on Health Services and two special Executive meetings on September 9th and 30th to consider the brief prior to presentation to the Royal Commission on October 30th, had resulted in delaying the second regular meeting from September 30th to December 2nd, 1961.

The minutes of the fifth regular meeting (1960-61 June 10th, 1961) were moved for adoption. Carried.

BUSINESS OUT OF THE MINUTES OF June 10th, 1961

(a) Members of the Building Committee (special committee) were named.

(b) Interim budget for the Special Research Committee. It was agreed "that action on the suggestion of the S.R.C. (to approach the Provincial Medical Board for possible financial assistance) be deferred until a final budget for this Committee is available for 1962.

(c) The S.R.C. on July 6th, 1961, had discussed two resolutions arising from the Annual Meeting 1961. The resolution from the S.R.C. was:—

"That we recommend to the Executive that the principle of the present schedule of fees for the private practice of medicine be maintained with the additional provision of proration not to exceed currently prevailing M.M.C. rates".

The Executive resolved: "That the recommendation of the Special Research Committee be received and passed on to the Committee on Fees and the Committee on Economics for action". Carried.

Minutes of 1st Regular Meeting (1961-62) - June 14th, 1961.

A motion for adoption of these minutes as circulated was carried.

Minutes of 2nd Special Meeting (1961-62) - September 30th, 1961.

A motion for adoption as circulated was carried.

BUSINESS OUT OF THE MINUTES OF September 30th, 1961.

In reference to the Executive Secretary's request for an interim committee to start consideration of the C.M.A. meeting in Halifax in 1965. Dr. D. M. MacRae was appointed chairman with authority to name the members.

Reports of Committees to 2nd Regular Meeting December 2nd, 1961.

Committee on Annual Meeting 1962 (Nova Scotian Hotel, May 21st, 22nd & 23rd).

The President, Dr. R. F. Ross, Chairman of the Committee on the Annual Meeting 1962 identified his Committee Chairman as follows:

Programme & Entertainment	—	Dr. H. R. McKean
Registration	—	Dr. W. A. McJannett
Housing	—	Dr. K. B. Shephard
Exhibitors	—	Dr. D. R. MacInnis
Ladies Committee	—	Dr. H. D. Lavers
Publicity	—	Dr. B. D. Karrell
Golf Tournament	—	To be appointed
Executive Secretary	—	Dr. C. J. W. Beckwith

He stated that his Committee chairmen had met on several occasions and that the programme to include business and clinical sessions and social activities was taking shape. It is planned to have progress reports in each Bulletin issued from January to April. The housing application form will also be published.

Committee on By-Laws.

To fulfill the requirements of the By-Laws of the Society Chapter XV that amendments ". . . .shall be published in the Bulletin at least two months preceding the Annual Meeting", the Committee on By-Laws presented to the Executive Committee a consolidation of the By-Laws including amendments approved by Annual Meetings since 1956. These were approved for publication.

The Committee on By-Laws recommended that the wording of para. 3 of the Constitution (Chapter 69, Acts of Nova Scotia 1861) which reads:

> "The Company may purchase, take and hold real estate to the value of ten thousand dollars"

be amended to read:—

> "The Company may purchase, take and hold real estate".

On motion, this recommended change was adopted subject to legality. The matter is to be referred to legal counsel.

Special Research Committee.

This report informed the Executive of the activities of the Committee in reference to the final preparation and presentation of the Brief to the Royal Commission on Health Services (October 30th and 31st, 1961).

A resolution "That Dr. A. A. Giffin should receive an honorarium to cover his absence from medical practice prior to completion of the Brief to the Royal Commission. . . ." was carried.

The report was adopted.

Committee on Fees.

This Committee reported having weekly meetings and requested representatives to have any communications from groups or members submitted promptly.

Liaison Committee, W.C.B.

The Chairman reported continued progress and expressed the opinion that the Committee was advantageous to the W.C.B. as well as to the Medical Society. A motion that this Committee be a Standing Committee of the Society was carried.

It was agreed that complaints from the W.C.B. representatives be referred to in the Newsletter of December 1961 and that the representatives from the Society to the Liaison Committee continue with endeavours to have these adjusted. The report, on motion, was adopted.

Special Committee on Presidential Insignia.

The Chairman of this Committee, Dr. Titus, presented a drawing of the proposed presidential insignia, as well as past president's pins, senior membership and Branch Society scrolls. The Executive commended the Committee for its work and approved the designs of the insignia, etc. It is expected that these will be available for the Annual Meeting 1962.

Special Committee on Specialist Register.

An interim report was accepted by the Executive with the provision that said report be referred to Branch Societies for comment and guidance.

Committee on Health Insurance.

The Committee reported on a meeting of members with the Nova Scotia Hospital Insurance Commission on October 17th at which a representative of the Nova Scotia Hospital Association was present. At this meeting a brief from the Nova Scotia Association of Pathologists and a memorandum concerning professional diagnostic radiological services was presented. The Committee had not received a reply from the Commission prior to the Executive Committee meeting. The Committee report was received.

Reports from the Committee on Economics and the Committee on Public Relations were adopted.

Correspondence.

The following items were dealt with:

(a) Letter from the Nova Scotia Hospital Insurance Commission requesting recommendations for appointments to the Professional Technical Advisory Committee in general practice, surgery and obstetrics. The present term of appointees in these classifications of practice expires on December 31st, 1961.

(b) A letter from the Editor of the Dalhousie Medical Journal inviting the Society to purchase a page for Society use in each of the three issues per year. The requested was referred to the Budget Committee with the recommendation that this be done.

(c) A communication from the C.M.A. Committee on Medical Education resulted in the Executive Committee changing the name of our "Committee on Post-Graduate Education" to the "Committee on Medical Education" thus enlarging the sphere of interest of this Committee to all phases of medical Education. Dr. D. C. Cantelope is Chairman.

(d) In response to a letter from the Provincial Medical Board, Dr. M. F. Fitzgerald was elected to complete the remainder of the late Dr. F. J. Granville's term.

(e) A letter of thanks and appreciation from Mr. Dale Dauphinee, Senior C.A.M.S.I. Officer, Dalhousie, was received. Mr. Dauphinee had been invited to and did attend the Annual Meeting of the Society 1961 as a guest.

Four items of old business were dealt with.

A number of items of new business and other business were dealt with. Among these were resolutions from the C.M.A. General Council relative to cancer and rehabilitation; Dr. R. O. Jones was nominated as alternate to Dr. D. I. Rice whose nomination as Divisional representative to the C.M.A. Executive 1962-63 has been sent forward; representatives to the C.M.A. General Council 1962 were selected as well as three alternates; a proposed study of bone tumours and the possible association with radiation hazards was endorsed.

The meeting adjourned at 4.30 p.m.

The date of the third regular meeting was set for March 3rd, 1962.
(N.B.—Events since December 2nd have caused the date of the third meeting to be advanced to February 24th, 1962.)

C.J.W.B.

ARTICLE

SIGMUND FREUD
A REVOLUTIONIST OF THE HUMAN MIND

By
NICHOLAS DESTOUNIS, M.D.*

Innumerable thoughts are born during every minute all over the world, but many of these thoughts are lost at the same time in which they are born.

Among these thoughts which are lost—these sterile and valueless thoughts —one thought may arise which will contribute to the changes of a whole era and of the whole cosmos.

Creative thoughts are extremely rare and the question is, upon which of those thoughts does the change of our intellectual, aesthetic, and practical cosmos depend?

Freud has been, and he is still, throughout the years an inexhaustible source of creative thought, and let us analyze how he decided to become a physician and also explore his brilliant career.

Freud's biographer, E. Jones, informs us that Freud wrote, ". .the theories of Darwin, which were then (1873) of topical interest, strongly attracted me, for they held out hopes of an extraordinary advance in our understanding of the world" and that this was one of the reasons he chose medicine as a profession (Bruner, 1958; E. Jones, 1953, p. 28).

While still a student Freud was awarded a research scholarshup to a newly established marine biological laboratory in Trieste, thus giving him his first opportunity to devote himself to biological research. Later he arranged to be transferred to Brücke's Physiological Institute where he studied the embryological origin of the nerve roots of a low form of spinal animalpetromyzon. It was in Brücke's laboratory that Freud also met Breuer with whom he revolutionized the field of psychology and introduced his concepts of psychoanalysis."[1]

Actually, Freud's brilliant career began as a neurologist. He published over twenty neurological and neuropathological papers, and his contributions to the above fields made him an authority on cerebral palsy. Furthermore, his study on aphasia (1891) is still considered as one of the classic studies of modern neurology. His great teacher, Charcot, at the Salpêtrière, influenced him so much that upon his return to Vienna he translated many of Charcot's works.

In a letter to W. Fliess (May 25, 1895)[2] Freud wrote, ". . .a man like me cannot live without a hobby horse, a consuming passion—in Schiller's words a tyrant. I have found my tyrant, and in his service I know no limits. My tyrant is psychology; it has always been my distant, beckoning goal and now, since I have hit on the neuroses, it has come so much the nearer. I am plagued with two ambitions: to see how the theory of mental functioning takes shape if quantitative considerations, a sort of economics of nerve-force, are introduced into it, and secondly, to extract from psychopathology what may be of benefit to normal psychology. Actually a satisfactory general theory of neuropsychotic disturbances is impossible if it cannot be brought into association with clear assumptions about normal mental processes."

In the course of his outstanding career, Freud abandoned hypnotic suggestion in the treatment of neurotic patients (hysterics) for the method of free association whose purpose was to bring into the conscious the infantile mem-

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ories which have been repressed into the unconscious, and thus he created his own therapeutic method and theory.

In his study "Contribution to the History of Psychoanalytic Movements" Freud writes that, "Breuer's cathartic method constituted a preliminary phase of psychoanalysis."

But who else influenced Freud in developing the science of psychoanalysis? I believe that Freud, being a Greek scholar, was deeply influenced by Aristotle, Socrates, and Hippocrates. The free association technique is based upon Aristotle's definition of tragedy, namely, "catharsis of pathos."[3] Furthermore, psychoanalysis is based upon Socrate's axiom of "self-knowledge". In my opinion, the majority of men can, only by the aid of psychoanalysis, arrive at self-knowledge. That is, in the complete and full consciousness of the pragmatic motivations of wishes and desires, and the elimination of esoteric psychic conflicts that make up this consciousness, man is made more or less independent and is able to rise above his pathos.[4] The power of psychoanalysis has become so great today that, little by little, all the exoteric forms of the interpersonal relationships between people have been enormously influenced by it.

But what other roles does the method of psychoanalysis play in our life? I should briefly mention here that psychoanalysis not only cast a new light on the general and individual manifestations of psychic life, but investigations into the unconscious led to very important discoveries with regard to the laws governing artistic creativeness. For example, this genius of psychoanalysis first applied his method in two brief studies entitled: "Leonardo da Vinci, A Psychosexual Study of an Infantile Reminiscence", and "Dostoevsky and Parricide".

Freud's pupil, Karl Abraham[5], also studied artistic creativeness and his paper on "Giovanni Segantini" is one of the most comprehensive works of the life and special mental make-up of a creative artist from the psychoanalytic point of view.

Artists and neurotics have much in common in their psychic manifestations. Perhaps in both, instinctive life originates in morbid strength and has undergone a complete change through an intensive repression. Both live partly in a cosmos of phantasy. In the neurotic the repressed phantasies are elaborated into the symptoms of his illness; in the artist these phantasies find expression in his creations.

Another rôle which psychoanalysis has to fulfil is to be utilized by leaders of the nations in whose hands lies the future of the whole civilized cosmos. By that I mean, and believe, that war and its catastrophic consequences can be prevented if these men receive psychoanalytic treatment which will enable them to arrive at self-knowledge and, therefore, to overcome their abnormal pathos to destroy the whole of mankind. I also believe that if the contemporary generation, which presents a greater freedom, is confronted with more honesty and sincerity, together with many of the problems of morality and physiology, this will be due to Freud's intellectual influence. Freud, too, realized something which was exceptional, namely, to make each man of our generation feel his influence independently.

Many people, perhaps, may say, "You exaggerate! We have never felt Freud's influence, for we have never read his books." It is an illusion for someone to believe that one thought or one concept will directly, rather than indirectly, influence people and furthermore, that he must read the work of a genius to be influenced by him.

Which are Freud's thoughts and discoveries? It is obviously a very difficult task to summarize in a brief article the fruit of a half century's work,

but we could say here that Freud gave a new explanation to the esoteric mechanisms of the human psyche and that through him one prototype psychological method was born and, at the same time, one therapeutic technique of mental diseases.

Since the beginning of the Twentieth Century the old psychology, the Pro-Freudian, was abruptly separated from the New Psychology. The Pro-Freudians believed that everything was regulated from the human cranium. Those whose professions called upon them to study men's dangerous impulses —doctors, judges, philosophers—knew how many secrets were hidden under the mask of humble and decent appearance of the civilized man. They were then asking for man not to be interested in his evil inclinations or, at least, to think of them as rarely as possible, to hide them, and to keep his evil desires silent.

Freud, however, asked himself, and logically so, "These inclinations, these impulses, what do they become?" And he answered, "They pass from the conscious into the unconscious where they become more dangerous."

The books that were published until 1900, and which were devoted to diseases of the nervous system, seem ridiculous to us today because the authors of that era were treating mentally ill patients with hydrotherapy, etc. Freud was the first to begin treating the psyche itself and not the organs, nevertheless, at the beginning of his practice as a young neurologist in Vienna, he lost his patients. The introduction of his new concepts provoked a "scandal". Even the faculty of medicine of the University of Vienna protested against this brilliant revolutionist of the human mind who was unreservedly teaching the influence of sexual instinct in many mental disorders. The fact that the Nobel Prize was not awarded to him was due to the hostility of the medical circles of that epoch. But Freud always maintained his self-conviction and, to our astonishment, he escaped the danger which always threatens the genius, namely, the enticement of glory. Freud lived throughout his life as a simple enemy of darkness and friend of light. He lived for over thirty years in the same house far from the activities and noises of the world, and yet like Faust, inspiration flowed from this humble dwelling to influence the entire cosmos.

His small study-room was decorated with Hellenic and Egyptian statutes. For many years he used to devote eight to ten hours daily to the treatment of his patients. But it would be an injustice, even in this brief article, if I omitted to mention Freud's contributions to other fields, such as, literature, aesthetics, religion, mythology, anthropology, and sociology.

Five years ago in the great scientific centers of the western world was celebrated the 100th anniversary of the birth of the greatest of psychiatrists who, at the dawn of the century, wrote in Vienna the "Interpretation of Dreams". His theory corresponds closely with that formulated twenty-four centuries earlier by the most eminent physician and the father of medicine on a small island in the Aegean Sea.[6]

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GENETIC INFLUENCES IN CHILDHOOD DISEASES

MAUREEN H. ROBERTS, M.B., Ch.B., D.C.H.

Halifax, N. S.

In two recent issues of the Bulletin have appeared articles on Genetics in which the writers have explained some of the more research aspects of the application of genetics to medicine. I will therefore try to confine myself to the clinical side and show how we are attempting to correlate the two and play our part in the accumulation of knowledge.

About fifty percent of the chronic illnesses of children have their origins before the child is born. Such conditions as hare-lip and cleft palate, club foot, mental retardation, idiopathic epilepsy and allergy, to mention but a few, are present at birth or appear to have been "predestined". However although the patterns of these diseases are laid down prenatally we must not assume that they are necessarily hereditary. Any condition present at birth is said to be congenital but all congenital conditions are not hereditary and some hereditary conditions are not congenital—that is they do not become apparent until much later in life. Huntington's chorea is an example of this. There are other influences at work prenatally besides the genetic ones. The so-called environment of the embryo includes (a)—the immediate environment—the uterus, placenta, membranes, etc. (b) the body processes and health of the mother —this includes her enzymes and hormones and her illnesses both acute and chronic such as rubella and diabetes mellitus. (c) the nutrition of the mother —this may be of great importance in situations where severe protein or vitamin deficiencies occur. (d) the induced or iatrogenic environment, the drugs administered by the doctor during the pregnancy e.g. thyroid extract, thiouracil, steroids, and cytotoxic drugs all of which may have a profound effect on the developing embryonic tissues. Included here is radiation—either therapeutic or diagnostic in large enough doses.

In many cases it is impossible to tell whether a particular defect has been caused by genetic or environmental influences. Cleft lips and cleft palates for example are defects which may be produced by either influence. Whereas these conditions may be inherited they can also be produced in experimental animals by a variety of stimuli applied to the pregnant mother such as the administration of A.C.T.H. or cortisone, X-radiation, deprivation of riboflavine etc.[1] Therefore we must be very cautious in predicting the outcome of future pregnancies in a woman who has borne a child with one of these defects.

One of the present major aims of paediatric research is to reduce the perinatal mortality rate. Congenital malformations (including erythroblastosis foetalis) account for approximately 20% to 30% of the total neonatal deaths. We are as yet unable to account for such defects as meningo-myelocele, anencephaly, tracheo-oesophageal fistula, multiple bowel atresias etc. By combined studies of the genetic make up of the mothers and children involved, detailed family histories, metabolic and viral investigations etc., it may be possible to discover how these conditions are produced. We know that erythroblastosis is due to a combination of genetic cause plus environment—a child of a certain genotype in the environment of a sensitised mother—and

because we understand the mechanism we are able to predict jaundice in the baby and take early steps to counteract its effects.

Another important field of research is in the study of mental retardation. It is becoming increasingly important that we attempt to investigate the cause of all cases of retardation, however hopeless. The discovery of a genetic cause may lead to effective steps in prevention or treatment. In this field in particular the combined efforts of many different departments—metabolic, psychiatric and genetic—are required. A genetics department will concern itself with a detailed family history taken by a skilled interviewer who will enquire about consanguineous marriages and affected relatives among many other things. This department should also be responsible for the detailed chromosomal studies on these patients. Phenylketonuria, galactosemia and others are due to a single enzymatic defect in each case. This prevents the complete breakdown of certain substances and allows the accumulation in the blood of intermediate products which appear to be toxic to the developing brain. As most doctors in the Province are aware a research project is at present in progress in maternity hospitals in Halifax and Sydney to search for babies with abnormal substances in the urine which would indicate some of the above defects.

Epilepsy is another problem of considerable magnitude in children. We all know that epilepsy is a disease with many widely differing causes. There is at least one group of the so-called idiopathic variety—the centrencephalic type—in which there has been demonstrated a hereditary tendency.[2] In this case the genetic factors do not seem to be simple but may be dependent on the interaction of several genes.

We have had some very interesting but rare cases at the Children's Hospital in the last few years. We have reported[3] three babies with epidermolysis bullosa letalis, a fatal disease of infancy thought to be caused by a recessive gene. The babies were cousins and all came from an inbred little community. Currently we have a case of xeroderma pigmentosum whose sister and first cousin have already succumbed to this recessively inherited severe disease. Again the parents are second cousins. Another family suffers from congenital spherocytosis and if they remain in this area we will doubtless be dealing in the future with the third affected generation as this disease is of dominant inheritance. Much more frequently found are the children suffering from cystic fibrosis. This disease is undoubtedly genetic in origin being probably due to a single recessive gene and early case anticipation has proved to be of great benefit to the younger group of patients.

Dermatoglyphics, the study of hand and foot print patterns, have shown that certain abnormal skin-ridge patterns tend to be associated with specific chromosomal abnormalities as in mongolism. This science is also used in twin studies as confirmatory evidence of monozygosity in cases where this may be of great importance—e.g. when organ transplantation is contemplated.

To me the possibilities for exploring the ultimate causes of disease is most exciting and Nova Scotia is a gold mine of possible explorations for anyone interested. Indeed the wealth of "gold" is so great that one really hardly knows where or how to start. In Halifax we now have excellent facilities for metabolic studies and soon we hope to offer chromosome counting and identification. Case finding studies are also in progress and correlation of the findings of these different groups should achieve some interesting results.

Public education has not kept pace with medical knowledge in these matters but we can hope that increased travel and education facilities will spread the knowledge that something can be done about many obscure defects and may curtail the habit of local marriage which is so often the cause of these abnormalities.

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BOOK REVIEW

Review of "Office Diagnosis" by Paul Williamson, M.D. 470 pp. Price $12.50.

It is stated in the author's preface that this book is a work on practical office diagnosis. He has attempted to present the philosophy and art of diagnosis as well as its science. In this aim he has succeeded reasonably well, although it must be pointed out that it is not such a unique one as suggested in his preface, since several other texts purport to do exactly the same thing.

The author of this text, however, does present his material in a somewhat different manner than do most authors, in the "down-to-earth" and almost conversational manner in which he writes. It certainly makes for very easy reading. At the same time he sometimes tends to gloss over some items or give a facile explanation of something or other without too much factual evidence. There are also numerous inaccuracies, mostly minor in nature, scattered throughout the book. This is perhaps understandable in a text written by a single author and covering such a large section of medicine.

The organization of the book is satisfactory. Symptoms on a regional basis constitute the division of the text into twelve sections with ninety-nine sub sections. It is noted that in this division he does not consider the Nervous System. It is true that most of the symptoms referable to this system have been mentioned under the section "Non-specific Symptoms". It seems that perhaps it might have been better to have collected these into a separate section on the Nervous System. It might also have been an improvement to have considered hypertension and hypotension along with the cardiac section instead of this one of "non-specific symptoms".

The assessment of the patient from the psychiatric standpoint has been dealt with in detail and there is frequent repetition, but it is perhaps better to have done this than to have under-emphasized such an important facet of office diagnosis.

The laboratory procedured described will be beyond the scope of many, if not most, practitioners but the material given is very instructive and I do not feel that the value of the text has been lessened by the inclusion of tests which many doctors would not be prepared to undertake.

The author adheres closely to the theme of diagnosis and does not stray into therapy except in the occasional referal to therapeutic tests as aids in diagnosis.

Altogether, this book gives a good survey of the diagnostic features of most conditions apt to be encountered in a practitioner's office. There are many useful and practical tips on diagnosis. The book is very readable. It should be a valuable addition to the active section of the practitioner's library.

R.L.A.

109th ANNUAL MEETING

The Medical Society of Nova Scotia

(Nova Scotia Division of the Canadian Medical Association)

HOUSING APPLICATION FORM

Dates of Meeting: May 21st, 22nd, 23rd, 1962 - Nova Scotian Hotel, Halifax.

Please Note: Re reservations at Nova Scotian Hotel —

Single room rate from $8.50 to $12.00 per day —
Single room rates in the old section of the hotel from $8.50 - $10.50; in the new section $11.50 - $12.00.

Double room rate (twin beds or double bed) from $12.00 to $14.50 per day —
Double room rates in the old section from $12.50 - $14.50 per day; in the new section $15.00 - $16.00 per day.

Please indicate on the application form the rate you wish to pay.

Dr. C. J. W. Beckwith,
The Medical Society of Nova Scotia,
Dalhousie Public Health Clinic,
University Avenue,
Halifax, N. S.

Please arrange a reservation at the Nova Scotian Hotel for the undersigned as follows:—

Single room .....at.....per day

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double bed at.....per day

I expect to arrive on May..... a.m. ..... p.m.

I expect to depart on May..... a.m. ..... p.m.

Names of persons who will occupy the above accommodation:

Name: .....

Address: .....

Signed: ..... Date.....

Applications for reservations at the Nova Scotian Hotel will be passed on to the hotel management for action and confirmation.

ARTICLE

CLINICAL EXPERIENCES IN THE MANAGEMENT OF VAGINAL DISCHARGE

T. A. FOSTER, M.D.
Saint John, N. B.

Of all of the major obstrical and gynaecological problems, with which we are faced the selection of my subject—vaginal discharge—, seems somewhat difficult to justify. However, I feel it is apropos for two very important reasons. Firstly, because of its frequency. Secondly, because, I am afraid, it is all too commonly mismanaged.

As a rough estimate I would venture to say that about 25% of all office gynaecology presents with the symptom of vaginal discharge, and when incorporated with other gynaecological complaints, probably represents close to 50% of office gynaecology, and while diagnosis and management of such cases is usually quite simple and the patients are extremely grateful, all too often the symptom is overlooked or dismissed with a casual "Why don't you try a vinegar douche?"

From an etiological standpoint, I think it is safe to say that any form of pelvic pathology may be responsible for some vaginal discharge, but from a practical standpoint there are only two major causes of vaginal discharge, *Trichomonas* and *Monilia*. However, for the sake of completeness I think we should list the more common causes:

1. Trichomonas.
2. Monilia.
3. Cervicitis.
4. Cervical Neoplasm.
5. Gonorrhoea.
6. Foreign Bodies.
7. Non Specific Vaginitis.
8. Increase of normal vaginal discharge.
9. Senile Vaginitis.

As mentioned above the diagnosis is usually quite straight forward, but before discussing specific diagnostic methods, there are a few general principles which are worth while noting. The history may be of some help, but is far from being diagnostic and while you may be able to get information as to whether it is worse before or after a period, whether there is any discoloration, mixture with blood, or whether there is any associated odour, or any irritation or itchiness, frequently the woman will only complain of vaginal discharge, and you must then proceed to examination. I would like to stress here that just as important as the examination of the patient, is the examination of the discharge and that it is impossible to make an accurate diagnosis without a microscope.

Now, while the technique of microscopic examination of vaginal discharge is quite elementary, I think it is sufficiently important to warrant a complete description of the technique that should be used. With the patient in stirrups, an unlubricated finger is inserted well into the vagina and a wooden applicator is inserted along the finger into the posterior fornix and the discharge thus secured is transferred and mixed with a drop of saline, which has previously been placed on a glass slide. This is then covered with a cover slip and examined immediately (one word of caution, many women, in an attempt at cleanliness before coming to see the doctor, will take a douche and thus wash out most of the vaginal discharge and make diagnosis impossible, so in such

cases she must be instructed to return in approximately a week without douching in the meantime.) It is also important to note that high power magnification must be used, as low power does not give sufficient magnification to identify the offending organisms.

Before proceeding to the two major causes—Trichomonas and Monilia, I would like to discuss briefly the diagnosis and treatment of the other causes listed above.

(1) CERVICITIS: visualization of the cervix and perhaps biopsy makes a diagnosis of erosion and/or chronic cervicitis. Cauterization is usually effective in eradicating the lesion. Wet smear examination of the discharge is essential here as in other conditions, because many of these patients harbour Trichomonas as well as their cervicitis and cauterization does nothing to cure the trichomonas.

(2) CERVICAL NEOPLASM: These usually present with a watery bloody type of discharge or else frank bleeding. Examination and biopsy quickly confirms the diagnosis, and appropriate treatment can then be started.

(3) GONORRHOEA: This in my experience is a very uncommon cause of vaginal discharge. When it is found it presents as a thick purulent type of discharge and frequently is associated with a urethritis. If a finger is used to milk the urethra a bead of pus can frequently be expressed from the urethral meatus. Smears, from the cervix and urethra showing a gram-negative intracellular diplococcus, is diagnostic, but if negative should be repeated on two or three occasions if the diagnosis is suspected. The treatments, of course, is penicillin, usually combined with sulfonamides. It is worth noting that gonorrhoea is a fairly frequent cause of vaginal discharge in children.

(4) FOREIGN BODIES: This is probably the most frequent cause of vaginal discharge in children and may also be the cause of discharge in the adult female, and such things as a forgotten tampax, or even a twenty dollar bill have been removed from the vagina on occasion.

(5) NORMAL DISCHARGE: in some women there appears to be an increased amount of normal secretion and the fastidious girl may complain of this. The discharge is whitish and non irritating and wet smear examination shows a normal cellular content with no suggestion of any infection. This also is quite common in normal pregnancy, due to increased pelvic congestion. It is sometimes difficult to convince these girls that there is nothing wrong, but an explanation that I have found reasonably effective is to compare the discharge with saliva and that, as some people have more saliva than others, some have more discharge than others. This explanation seems to satisfy the majority of them, but of course this explanation must never be used unless the patient has been carefully examined and everything else ruled out.

(6) NON SPECIFIC VAGINITIS: While this condition undoubtedly does exist, because numerous papers have been written on the subject and drug companies have a variety of medication including powders, ointments, antibiotic creams etc., that are supposed to be effective in the treatment, to the best of my knowledge I have never seen a case of non specific vaginitis. I believe that in most of these cases Trichomonas is the offending organism and that careful and repeated examination will permit accurate diagnosis and specific treatment.

(7) SENILE VAGINITIS. The age of the patient is a help in making a diagnosis here as most of them are elderly, unless they have been ovariectomized (surgically castrated). The local use of dienoestrol cream is usually quickly effective in controlling the discharge. Wet smear examination is still important as Trichomonas is no respector of age. The characteristic finding is of pus cells

mixed with basal epithelial cells—that is small, round epithelial cells, rather than the cornified and pre-cornified cells of the pre-menopausal patient.

And now to the two most frequent and important causes of discharge.

(8) MONILIA: Until recently this was rather a rare cause of vaginal discharge and almost exclusively present in the pregnant patient, but with the advent of the broad spectrum antibiotics, it has become a very frequent cause of vaginal discharge, occurring in the non-pregnant just as often as in the pregnant patient. It is characterized by intense pruritis with a minimal amount of discharge and on examination presents a picture of vulvar excoriation and whitish patches, not unlike curds, seen at the introitus and further up in the vagina. This condition is also quite frequent in diabetics, so that urinalysis must always be done. Diagnosis is made by wet smear examination of some of these whitish patches and the visualization of mycelia under the microscope. These are quite easy to identify—they are usually present at the edges of a clump of epithelial cells and look not unlike pieces of bamboo.

Until recently the treatment of this condition was extremely unsatisfactory, gentian violet applied in the office, or a gentian violet cream or jelly which the patient used herself, being the only effective method. This was extremely messy and almost as bad as the disease. A few years ago a preparation called *Mycostatin* became available and is specific for monilia; this has revolutionized the treatment of monilia—it is almost 100% effective and apparently the organism doesn't develop resistance so that the treatment can be used over and over again if necessary. and sometimes it is necessary during the course of pregnancy. Treatment consists of 15 vaginal suppositories, one used nightly and dramatic improvement in symptoms can be expected within forty-eight hours. If the husband is suspected of being infected as well, mycostatin oral tablets can be used in the treatment of the husband at the same time. Some patients seem extremely prone to monilia infection and may develop symptoms every time they receive an antibiotic and in such patients a preparation containing mycostatin should be given, or mycostatin vaginal suppositories used in conjunction with the oral or intramuscular antibiotic.

(9) TRICHOMONAS: Trichomonas is undoubtedly the most frequent cause of vaginal discharge and certainly accounts for the largest group of gynaecological patients seen. This infection can occur in any age group, from the small child to the elderly female. However, it is certainly more common in the child bearing period. Symptoms are chiefly of a profuse, foul-smelling discharge with either pruritis, irritation or chaffing as a secondary sympton. The text book picture of trichomonas is one of perineal irritation associated with a green, frothy type of discharge, but this is not always present and there may be no external signs of irritation and the discharge may be of a whitish color. In the full-blown infection there may be petechiae on the cervix and vaginal mucosa as well. In any event the diagnosis can only be made with certainty with wet smear examination and visualization of the trichomonas under the microscope. The trichomonas is larger than a white cell and is easily recognized because of its jerky movements across the slide.

The treatment of trichomonas is reasonably satisfactory but requires patience and perseverance on the part of the physician and patient, the longer the symptomatology the more difficult it seems to be to eradicate it, but as a general rule about 80% can be cured with one course of treatment and the large majority of the remaining group cured with repeated treatments. A very small percentage of women must treat themselves more or less continuously for the rest of their lives. I have had one patient who had worn a pad

constantly for fifteen years and several months treatment were required before the infection was finally brought under control. I would like to issue a word of caution at this point in the treatment of trichomonas as there are many products on the market which are reportedly effective, but in my experience most of them are valueless, and this certainly includes most of the creams and all of the products that are reportedly effective against trichomonas, monilia, and non specific vaginitis.

My standard treatment for trichomonas, until recently, was one stovaginal tablet inserted at bed time every night for a month, preceded by a vinegar douche of four tablespoons of white vinegar to a quart of warm water. This must be carried out through a period, both the douche and the suppository. As mentioned previously this was effective in about 80% and repeated two or three times resulted in cures in most of the remainder. Within the past year a new product has come on the market in the treatment of trichomonas that seems to be even more effective and this is called *Flagyl*. Treatment consists of vaginal inserts, one each night for ten nights with an oral tablet twice daily for the same period of time. It is also recommended that the husband receive the oral tablets at the same time the wife is being treated. This method of treatment seems to be highly effective and results approach 90%. It obviates the necessity of douching; However, it is still a trifle expensive,—a course of treatment costing somewhere between $12 and $15.

For those cases that do not appear to respond—treatment in the office should be carried out on alternate days, consisting of washing out the vagina with green soap and instilling aquaflavin in the urethra and painting the cervix with iodine and then insufflating the vagina with Stovaginal powder. This is usually helpful. One other product that seems to be of some value in the resistant cases is *Vagisec* and this can be used either by the patient at home or as an office procedure.

In conclusion I would like to reiterate the necessity for examination, including wet smear examination of the discharge and stressing once more that the most frequent causes are *Trichomonas* and *Monilia* and that if this is kept in mind the vast majority of patients can be cured. The treatment is always specific and should never in my opinion include douching just for the sake of douching, or non-specific medication, (that supposedly is effective in the treatment of Trichomonas, Monilia, and Non Specific Vaginitis.)

(Presented at Saint John Medical Society Spring Clinical Session. 1961.)

ARTICLE

MEDICAL PUBLIC RELATIONS

Luncheon address, June 12/61—Medical Society of Nova Scotia Convention. Ingonish, N. S.

"The Public Be Damned"

This was the response of W. H. Vanderbilt, one of the U. S. Railroad "Robber Barons", when a reporter questioned him about how a certain amalgamation of a railroad would affect the public. Are *we* too far from the Public? The old tradition in medicine was a deliberate distance. Some of it was to cover our ignorance, e.g. the writing of prescriptions in Latin was not only to communicate with an apothecary or to another physician but it also reflected our empiricism (a eupheumism for "shot-gun mixtures") in the older non-scientific approach to many illnesses.

Unfortunately, old traditions die slowly. As empiric medicine began to be replaced by scientific medicine, shortly after the turn of the century, its traditions included a sort of mysticism. There were few specific remedies. Treatment was largely traditional, empiric and supporting. At one time bloodletting and purging were used for nearly everything. In fact only a half century ago, a very prominent and respected doctor stated that if it had to do so, the medical profession could practice medicine with morphine, castor oil and quinine—quinine being the only actual specific there was.

Hence, it is little wonder that empiricism and mysticism flourished. Now, much of the empiricism has changed and diagnosis and treatment are on a sounder scientific basis. The average patient is better educated and he wants to know the "why's and wherefore's". But has the mysticism persisted? I fear that it has.

"Many factors impel us to be more frank with the public, two are of special significance.

1. Medical education has become more prolonged and expensive.
2. Hospitalization, diagnosis and therapy have become more costly, and the patients, those who pay the costs, can no longer be kept uninformed. They want to know and they *are entitled* to know why certain procedures are necessary, what they are going to cost and why." (excerpts from the Secretary General's Page, World Medical Journal, November, 1960).

The doctor of today must shed his cloak of aloofness and meet his patient's need for information. A patient may become resentful if he does not understand the reason for an X-ray or a certain laboratory procedure, or why a certain course of treatment will be expensive. He does not understand these things because the doctor does not take time to explain them. Explanation before action prevent complaints. Explanations after the complaints have been made often leave hard feelings.

It is easy to understand why the public relations of the medical profession begin at the doctor-patient level. In fact if all doctors considered themselves as public relations officers of their profession in their contacts with their patients, much of the problem would be solved.

> "The image of medicine is simply an extended likeness of the physician and his colleagues, reflected in the mirror of public opinion, It can be warm and sympathetic, or cold and impersonal. Actions speak louder than words; and words are without value unless they are backed

up by deeds. The image of our profession is the reflection of our substance and not our shadow."
(Dr. E. V. Askey—Presidential address—AMA Convention, Los Angeles, California).

We know that medicine traditionally has been reluctant to tell its story. It has felt that good deeds are in themselves sufficient evidence of its competency and humanitarianism. But good deeds are not enough and our communication with the public needs a drastic overhaul. There are many eager receivers among the public but very few doctors are sending any messages. Fortunately, this attitude is changing and we find the medical profession is becoming increasingly public relations-minded.

But it doesn't mean that we can solve our problems over-night by waving a magic wand. The solutions can be found only by hard, sustained work. For example, one of medicine's greatest weaknesses is that all-too-often there is more agreement among doctors on how medicine should *not* be thought of by the public than how it *should* be thought of. The biggest question is what we are *for*, not what we are against. Effective medical public relations can no longer be viewed solely as a preventive or holding operation, but as a creative, organized activity to strengthen the future of medicine. (Excerpts from Leo E. Brown, A.M.A. Public Relations Department, editorial, World Medical Journal, November, 1960).

"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." (Jack Golding—N. S. Medical Bulletin, December, 1960). Since the days of the French and American revolutions the days of the aristocrat were numbered—(though at times some of us feel that they are returning and though the Divine Rights of Kings has gone, some have supplanted it with the Divine Right of Civil Service Regulations!) The days of aristocratic medicine are gone or going fast—and we should speed its passing, otherwise like in the French Revolution we are likely to lose our heads!

Within the medical profession we have a very interesting variety of personalities. We may be described as entrepreneurs, (variously described as making something out of nothing, or living by one's wits) prima donnas, rugged individualists, the despair of the organization man and the bureaucrat and the last of the big time spenders.

But we make our living,
establish our reputations
and found our medical dynasties
on HUMAN suffering.

So those who buy our product, healing, should know about the manufacturer and his product. We have a captive clientele—they all are born, they all become sick, *so* they HAVE to come to us. Part of human nature resents having to come to us and though at first the patient appreciates us curing or helping them, he later thinks "why did the doctor charge *so much?* After all doctors have the highest incomes, he has lots of money, etc."

It is my opinion that there has been too much emphasis on the economic aspects of the medical public relations. First we should tell our story.

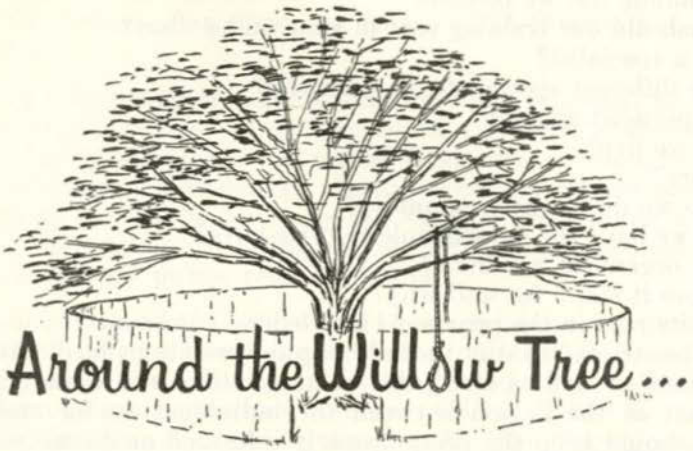
Where did we come from?
What training did we receive?
How much did our training cost in time and dollars?
What is a specialist?
What do different specialists do, and why?
Why a specialist anyway?
How do we live?
Our hours?
What do we do in the community?
Why do we have the fee schedule that we have?
What is organized medicine?
What does it stand for and why?
What is its part in the provincial and federal community?

It must be stressed that in the field of public relations medical associations have limitations as well as strengths. "Associations can issue general statements and act as the liaison between the individual doctor and the press. Associations should keep the press properly informed on advances in medical science. Otherwise the press will obtain information from other sources which are not always reliable. If a medical association establishes close relations with the press, it will find the press ready to cooperate and print accurate medical news." (World Medical Journal, Nov. 60 P.R. supplement) My own experience in the past three years in Nova Scotia as Chairman of the Public Relations Committee confirms these statements! ! An informed press is also more sympathetic and understanding of the medical profession's viewpoint on the socio-economic aspects of medicine. Unless the medical profession has an active alert group which is always available and informed and ready to speak, the doctor's story goes unheralded.

"The Medical Profession must come out of its shell; keep the public adequately informed of what it should know; support its medical societies and see that they are equipped to deal with problems in which the public is interested; and finally each doctor must be an individual spokesman for freedom, humanitarianism and the protection of the patient as a whole individual." (World Medical Journal, ibid)

Yes, we are a group apart, we have to be because of our training and our calling. *But* we must be humble with the great responsibilities placed upon us. — 'Walk with Kings yet keep the common touch' — We must be worthy of our hire but also worthy of our patient's trust, throw off the "feudal aloofness" and become truly leaders of the people.

F. A. Dunsworth, M.D.



ADDRESS TO THE SAINT JOHN MEDICAL SOCIETY

MAY 24/61

PART I

I had thought to speak tonight on some of the aspects of medical life in this 'New Era', which begins to emerge as a period of politics, public relations, and research. Though you may suffer under my tongue for a while you may be assured that it will not be soon repeated as I am privileged to visit Saint John but once every fifty years. The first occasion was as a lad of eight or nine when I accompanied my mother on a visit to relatives. We arrived on a beautifully hot summer day and the next morning dawning sunny and warm and I was early up and out and soon found myself engaged in a game of cowboy and Indians with a group of neighbourhood children. Hoping to make a big impression I drew from my pocket what I believed to be a beautiful weapon. It was a glass revolver filled with jelly beans.

At this point my first observation in research, we might say sociogeographic research, was forcefully impressed on my mind as I saw the development of the naturally aggressive attitudes of the New Brunswick boy to his counterpart from the little province across the Bay. Eying disdainfully my handsome and succulent weapon, a lad (obviously a born leader) who lived across the street, announced in bold terms, "I have a real revolver at home". This immediately recaptured attention from the cheap Nova Scotian usurper, and was followed at once by that sly, coaxing, goading, disbelieving, "show it us then" challenge, at which small boys excel the world's cleverest war-mongers.

The freshly reinstated idol crossed the street (somewhat slowly and reluctantly I hoped) to fetch the real revolver, while the rest of us waited in obvious and loud disbelief for his return. He was back in a few minutes and produced the revolver. "It's real all right" he said modestly, "only it doesn't work". He handed it to me, the more to deflate the obnoxious foreigner, and here I had my first experience of that peculiar blend of truth, error, friendship, animosity, helpfulness and jealous misunderstanding which has marred the good relations of the Maritime Provinces ever since the tragedy of Confederation, and which requires of the officers of APEC an olein poise unexcelled in any diplomatic service in the world. I can see that revolver yet. It had a

shiney nickleplated barrel and a pearl handle, as real as could be, and it didn't work, because, as he said, the trigger was stuck.

The nervous woman who lived in the lower flat (in whose yard we were fighting the Indians) was coming out the back door with a basket of clothes for the line just as the trigger came unstuck, and with the roar of that old pistol she screamed and spilled the contents of the basket down the steps and into the dirt. Not one of the cowboys moved, but in every window in sight a face appeared, and presently there was a noise of clattering down the high back steps from the upper flat as my mother and aunt came hurrying to investigate. I was hustled out the gate to reach the shelter of the upper flat by the front stairs (to avoid the irate woman gathering up the soiled laundry) and that gallant little troop of Indian hunters disbanded forever. That afternoon I was taken from the neighbourhood, with firm adult company, to spend the remainder of the day at the Zoo.

Next morning was sunny and warm, and I was early up and out of doors looking for companionship and play. But no companions appeared. Those careful Loyalist mothers were unwilling to allow their darlings to play with that horrid Nova Scotian brat, and I was on my own. That back yard was remarkably tidy, surrounded on three sides by a high board fence, unpainted, as was the back of the set of flats. A high wooden stair came down from the upper flat to a common landing and thence six or eight steps down to the yard, which was fairly clean, quite level, and the soil dark, almost like rolled cinders, with only an odd plantain growing here and there. To the left of the landing in the lower flat were two windows, one large (kitchen) and one smaller lighting a combination pantry and pot cupboard. Under the landing were kept the trash barrels, and on this occasion only was a lifelong pattern of profitless research into the content of garbage bins relieved, for I was promptly rewarded by finding an old umbrella spine, bare of silk and clear of ribs and stays It was of brown enamel over steel, as smooth and glossy as new from it's slender pointed tip to a flat black handle set straight and at right angles to the shaft. This immediately suggested a golf club and with a bit of rubbish serving as a ball the game was on. Two or three strokes took me to the back fence, each one a little better than it's predecessor, and I turned to go back over the course, trying hard for both style and distance. At about mid-yard I took careful stance, layed the club well back over the shoulder and swung thru. The nervous witch of a woman who lived in the lower flat had just entered the pantry from the kitchen when the club, lacking a firm grip on the smooth tapered end, slipped out of my hands and sailed in a slow, graceful, agonizing arc thru the glass, clattering to a dreadful stop in a rattle of pots and pans. The scream that followed pierced ears, walls, doors, and ceilings and hung, a thin, vibrating tremor in the air long after the tinkle of glass and rattle of pots had subsided. Again the windows were filled with faces and I, rooted to the soil like one of the plaintains, saw with relief my mother hurrying again down those long back stairs. That afternoon I was contained in the ball park.

The following morning was sunny and lovely again, and I was up early, dressed, breakfasted and conveyed hurriedly to the waterfront where we embarked for home. There were no threats, and no suggestion of banishment, but that was the last I saw of Saint John. I heard later that the nervous woman who lived downstairs was taken the same day to a kind of Zoo, and put in one of the cages.

Thus began for me, interprovincially at least, a lifetime of indifferent 'public relations', and this is my daring, my first return to Saint John.

Public Relations has as many faces as a politician, and as many moods as a poet. Like poetry too it changes form and meaning with the years and what may interest one generation is ridiculed in another. Consider the changing concept in this:

DEFINITION OF A POEM

When I was a youth
I read John Keats and knew
That a poem was a sublime thought
Beautifully expressed in words.

When I was a young man
I read T. S. Eliot and knew
That a poem was a sick dream
In a drugged sleep.

When I was an old man
I read Irving Layton and knew
That a poem was the sterile emission
Of a gelded fantasy.

So Public Relations, in it's definition and direction can be as variable as that. It can represent the effort of a 'pressure group' to influence the Public, or it can serve Authority to influence and control the People. It can be good or bad: it can be informative: it can be persuasive. It appears in our time to be a froward brat, the bastard child of a painful intercourse between various conflicts of desire in our economy. It came to maturity during the war years when Industry lost control of Efficiency, and was obliged to recruit the assistance of 'public relations experts' to conceal it's inadequacies. A public relations expert is an individual with good press contacts, who is specially skilled in keeping the public from knowing how badly you are doing. He has the sort of training that devises a little man like 'Reddy Kilowatt' to sooth your anger when your lights go out; or like Willie Water to explain why only dust runs from your taps. In medicine we need a cute little fellow, carrying a black satchel, called Donald Doctorbag, to explain how we all happened to be on the golf course when someone got a splinter in the finger. The children would love this. We should of course have in reserve a fierce looking fellow in pirate costume, with a scalpel in his teeth and a patch over his eye to explain why we feel it necessary to raise our fees. We might call him 'Doc Deadeye'. Labor would simply gush over him!

Bad 'public relations', I always thought, grew out of a nightmare in the C.M.A. office. However it developed, the term is in quite general misuse. By definition it means 'organized publicity'. In that light medicine has no public relations. When we speak of 'bad public relations' we really mean that we are the recipients of unfavourable notice, the victims of somebody's organized publicity against us. Such attacks must be initiated by individuals or groups who are either venting a spite, grinding an axe, or sincerely trying to improve the service. Naturally we would like to counter these attacks. We would like the Press, when they have occasion to write anything about doctors to canvass the situation carefully for aspects which are ennobling to the profession and run the story slanted in that favourable light. How naive can you get?

Our publicity becomes more political than professional in the heat of kindling electoral fires, but if our public image is bad, and some of us do not believe that it is bad, it must at least be amenable to rational consideration and analysis. There are various aspects of legitimate concern, such as:

1. The quality of the service
2. The availability of the service
3. The cost of the service.

Then there are less valid areas of public and professional reaction, such as:

1. Medical personality
2. Medical apartheid
3. Medical opulence.

Regarding the quality of service: The public is not competent to judge the quality of service and tends to confuse quantity with quality. Doctors know full well that maximum medical attention is not synonymous with optimum medical care. It is a peculiar anomaly that as the quality of medical care has improved, the regard of the public for the medical profession has deteriorated. This is in part due to the fact that in many diseases which were once serious and prolonged, cure comes about so rapidly in these times that a warm patient-doctor relationship does not have time to develop: in part also to the efficiency of modern medical-surgical techniques, which, by removing the dread of pain and the scourge of infection, have minimized the patients fear of impending agony and so reduced his awe of and reverence for, the doctor. One might add that it is also a bit difficult to feel deep reverence for a joker in a striped sport shirt, with a cigar in his teeth. There has been no time in all the history of mankind that the quality of his medical care has been so good, yet so little appreciated, and this in a time when the quality of most human effort in the western world is deteriorating.

Regarding the availability of service: The principal area of criticism here is in weekend, night time, holiday, emergency and deep rural service. This is admittedly difficult. Twenty-four hour duty, week in, week out, eleven or twelve months a year is a hard chore under which many of us have labored for a lifetime. It is unnatural, unhealthy, and restricts the enrichment of learning and personality, and, in these modern times, makes the medical life unattractive to many possible new recruits.

Schools of thought regarding off-hour and emergency medical service vary between wide extremes. One group says, "We are professional people gaining our livlihood by selling our training and skill to those who wish to employ us and our responsibility is to those, and only those, who are currently under our care." These are the well trained, professionally competent, morally sound, socially orientated scoundrels who practise on the sunny side of the Caduseus. At the other extreme is a group who would fasten on the private practitioner's conscience the responsibility, not only for his own sick, but also for any person who may at this time, or some other moment, become ill or injured. These are the well trained, professionally competent, morally sound, spiritually orientated scoundrels who, confused by an admixture of economic necessity and Christian charity, practise their art with furtive feelings of guilt on the shady side of the Cross.

This latter charge upon the conscience and pockets of private practise seems reasonable until one considers the many areas of diagnostic and treatment medicine into which Government, as Public Health or some other agency has

projected it's free, nine to five, five day week services. I am very much inclined to suggest to those who have organized out of my hands and resources the care of the tuberculous, the cancerous, the syphilitic and the insane, that they organize out of my hands and responsibility the off-hour and emergency service as well! It makes very little difference to the hunger of the private practitioner whether the meat is taken from his table by two men on half-time pay, or one man on full-time salary.

Regarding the cost of the service: This has increased less since 1939 than any other area of human endeavour. The cost of sickness has obviously increased, but this is due largely to factors other than physicians services. In Nova Scotia's largest general hospital, the standard ward bed that cost three dollars per day in 1939, costs something over twenty-one dollars today, and the doctor is still caring for the patient without any remuneration whatsoever. The private room, in which in 1939 the patient recovered from his hundred dollar appendicectomy cost four dollars per day. In 1961 he recovers from his one hundred twenty-five dollar operation in a room costing in excess of twenty-seven dollars/day, an increase of 500% for the hospital bed as against an increase of 25% for physicians services.

Children, when ill, want their mothers. It would seem also, from a study of Labors brief to the Saskatchewan Govt. that many adults when ill want their mother too,—complete with certification in the specialty indicated and at no advance over the rates paid the hand that rocked their cradles! Such people are impractical, immature visionaries who want to get something good without paying for it, but who do not realize that good medicine can not thrive in captivity in a democratic country. The best medical care, the best regulator both of the amount of service demanded and the quantity of care given is in effect where there is a good doctor-patient relationship engendered by the acceptance of a mutual responsibility, the doctor to see that his patient gets the best medical care available, the patient to see that his doctor is paid. This is human nature. Political parties cannot alter it unilaterally, or by compulsion.

To have effective free medicine in Canada, it will first be necessary to form a New Party (The Christian Communist Party), throw the disciplinary net of Communal Responsibility over Labor, Management, Capital and all the Little People and then, when the shackles are clamped and locked and they are sick at heart, we will gladly heal them with Socialized Medicine out of the sweet, despised charity of our hearts! One sometimes gets the impression that the goal of Labor is an economy in which the learned professions are conscripted into civil service while Labor remains free and undisciplined. It is a good thing to see Labor finally identified with a political party. It will, we hope, put an end to government through the irresponsible dictatorship of Unionism.

J. W. REID, M.D.

(To be concluded)

PERSONAL INTEREST NOTES

Halifax Medical Society

January 17, 1962—The monthly meeting was held at Camp Hill Hospital to discuss routine business, and a clinical presentation by the staff of Camp Hill Hospital on a "Case of Hyperparathyroidism".

January 4, 1962—Dr. S. Donald MacKeigan, Dartmouth, has discontinued his practice to take up an appointment to the Medical Outpatients Staff of Camp Hill Hospital, effective January 15, 1962, it was announced by the Civil Service Commission. Dr. MacKeigan has been certified in surgery by the Royal College of Physicians and Surgeons (Canada) since 1955.

Dr. A. B. Crosby, resigned from the Medical Staff of Camp Hill Hospital because of duties at the New Halifax Infirmary.

January 19, 1962—Dr. C. D. Vair, Dartmouth, was installed as President of the Dartmouth Gyro Club at their annual meeting. Dr. F. J. Barton was also elected as one of the directors for a period of two years.

Several doctors have recently opened offices for the practice of various specialties in the City of Halifax:

Dr. Alvin J. Buhr, for the practice of Orthopaedic Surgery in association with Dr. B. F. Miller, Medical Arts Building, 5880 Spring Garden Road, Halifax, N. S. Phone 423-8868.

Dr. Neville Elwood, Eye Specialist, 319 Barrington Street, Halifax, Phone 423-7463.

Dr. D. A. Gillis, for the practice of Paediatric Surgery, 5880 Spring Garden Road, Halifax, N. S. Phone 423-8693.

Dr. Bernard J. Steele, for General Surgery, 6387 Coburg Road, Halifax, N. S. Phone 422-5922.

The two local medical fraternities held their annual initiation Banquets and annual balls recently, Nu Sigma of Phi Chi on January 10 and 12, 1962; and Alpha Eta of Phi Rho Sigma on January 18, and 19, 1962.

Defence Medical Association

January 29, 1962—The annual meeting of the D.M.A. is to be held in the Officers' Mess Halifax Armouries, North Park Street. The question of increasing local dues by some $3.00 per member in order to continue National Meetings and so perform the role of the Association is to be discussed at the Annual Meeting.

University

February 5-7, 1962—A short course in Psychiatry was presented by the Department of Psychiatry and the Post-Graduate Division, Faculty of Medicine.

February 6, 13, 20 & 27, 1962—A second course in "Cardiac Auscultation" by Drs. D. L. Roy and R. N. Anderson was presented at the Victoria General Hospital for General Practitioners and supported in part by a grant from the National Heart Foundation of Canada, sponsored by the Post-Graduate Division, Faculty of Medicine.

Feb. 26-28, 1962—A short course in surgery was given for general practitioners, the mornings being spent in the operating rooms of the Victoria General Hospital and the afternons in lectures.

March 1, and 2, 1962—The course in surgery was followed by a course in neuro-surgery and neurology, with Dr. E. H. Botterall, Toronto as guest.

Dean C. B. Stewart of the Faculty of Medicine received a Fellowship, without examination, from the Royal College of Physicians and Surgeons (Canada), being one of three outstanding men in the field of Medicine so honored. This was given in "recognition of his outstanding contribution to medical education and medical research."

Births

To Dr. and Mrs. J. F. Boudreau, a daughter, at the Halifax Infirmary on January 16, 1962. (Seventh child)

To Dr. and Mrs. Donald C. Brown (Eleanor Buck, R.N.) a son, Michael Howard, at the Highland View Hospital, Amherst on January 9, 1962.

To Mr. and Mrs. David Keddy (Interne) (nee Nancy Bennett) a son, Stephen Alexander, at the Grace Maternity Hospital on January 3, 1962.

To Dr. and Mrs. Harold Nason (nee Norma Smith) a daughter, Donna Lynn, at the Halifax Infirmary on January 9, 1962.

To Dr. and Mrs. Rudolph (Rudy) Ozere, a son, Christopher Paul, at the Halifax Infirmary, on December 31, 1961. A brother for Tommy.

To Dr. and Mrs. B. L. Reid (nee Irene Hickman) a son, David Byron, at the Grace Maternity Hospital on January 16, 1962.

To Dr. and Mrs. B. J. Steele (Theresa McArthur) a daughter, Anne Leone, on January 12, 1962 at the Halifax Infirmary.

Coming Events

May 21-23, 1962—109th Annual Meeting of the Medical Society of Nova Scotia, Nova Scotia Hotel, Halifax.

June 18-22, 1962—95th Annual Meeting of the Canadian Medical Association, Winnipeg, Manitoba.

June 10-14, 1963—96th Annual Meeting of the Canadian Medical Association, Toronto.

Curtin, J. A., Petersdorf, R. G., Bennett, I. L. Pseudomonas Bacteremia, A Review of Ninety One Cases. Annals of Internal Medicine, 54: 1077-1106, June 1961.

Of 88 patients suffering 91 bouts of Pseudomonas Bacteremia, only 15 survived. The associated disease state was the most important single factor affecting the outcome. Suspicion should be aroused by (1) Infection of the umbilical stump or the skin of premature infants, (2) Sudden deterioration in the status of children with nephrosis or mucoviscidosis, (3) Leukemic patients with leukopenia who are receiving antimitotic steroids and folic acid antagonist, (4) Patients undergoing therapy for serious staphylococcal or coliform infection in whom worsening in the clinical picture occurred after an improvement.

L.C.S.