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The NOVA SCOTIA MEDICAL BULLETIN

EDITORIAL COMMENT

By FRED R. MACKINNON

President of the Nova Scotia Society for the Care of Crippled Children*

We have had phenomenal growth in the numbers and activities of voluntary health and welfare agencies during the past fifteen years on the local, provincial and national level. Prior to 1945, only two organizations, the Canadian Red Cross and the Canadian Tuberculosis Association, were well known in this field of work. Immediately following the Second World War, economic prosperity combined with new skills and knowledge in the areas of medical science and community organization resulted in a rapid expansion of health and welfare agencies for the education of the public and control of certain disease entities such as diabetes, multiple sclerosis, rheumatism and arthritis, cancer and polio, to mention only a few.

The program of federal health grants commenced in 1948 and some of these organizations have been assisted directly and indirectly by these grants. The Nova Scotia Society for the Care of Crippled Children has, for example, operated a crippled children's registry for a number of years and the cost of the registry is paid by the federal grants made available through the Provincial Department of Public Health. It should be emphasized, however, that only a very small portion of the total support of all these voluntary agencies comes from government and the greatest part of their revenue has been and continues to be raised in a variety of ways through such devices as Christmas and Easter Seals, the March of Dimes campaign, annual appeals to special names, Community Chest Appeals, United Funds, etc.

While the list of such organizations is growing, it is far from complete. It is worthy of note, for example, that there is no organization specifically concerned with the control and treatment of epilepsy and yet, this is a crippling disease with very considerable social and economic effects on the individual and one in which an organization could be of great assistance not only in the area of research and education but in rehabilitation as well. Time does not permit reference to other omissions just as important as epilepsy.

What of the future? What are some of the problems that have arisen as a result of this phenomenal growth? Is it possible that some of the functions now performed by these organizations will or should be taken over by government? What are the prospects for the development of new organizations to cope with research, education and rehabilitation problems in diseases such as

*Mr. MacKinnon is Deputy Minister of Public Welfare for the Province of Nova Scotia.

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epilepsy? Are the existing organizations adequately supported by the public? Are they efficient?

I would like to make three observations which I think are pertinent at this time.

FIRST. Up to the present time the voluntary donor has on the whole received good value for the contributions he has made to these voluntary health and welfare organizations. One might select any one of them and point out a worthy list of accomplishments. The community has been made aware of specific diseases. Casefinding has been helped immeasurably. Early detection and treatment of disease have been made possible. Rehabilitation has been given a new impetus. Control measures have been instituted by the public authority and in several other ways the public authority —federal, provincial and local—has been persuaded to accept responsibility for new programs which without the promptings of the voluntary agencies would never have been undertaken. The voluntary health and welfare agencies after fifteen years can therefore take justifiable pride in what has been done.

SECOND. The community is reaching a saturation point in relation to its financial ability to carry the expanding voluntary health and welfare programs. Having established voluntary health and welfare agencies which do a good job, there is an unfortunate tendency across Canada to want to keep all of these structures and their functions intact as a voluntary responsibility long after some of them have ceased to perform any useful or worthwhile function in the community or after the point has been reached when some or all of their functions should be taken over by government.

The effect of this is obvious. Up to 1945 all our communities had accepted a fairly onerous financial responsibility in supporting the traditional health and welfare agencies that had been operating for a number of years. Since 1945, the new agencies have greatly increased the financial load. Because many of the newer agencies have more public appeal, some of the older ones have suffered accordingly. We find a situation in the City of Halifax, for example, where there are a growing number of health and welfare agencies in the United Appeal and at the same time too many outside the Appeal. There is no system or organized way of knowing what agencies are necessary and efficient and should remain as a voluntary responsibility, what functions should be taken over by government or what agencies should cease to exist. The result is, of course, that many of the best agencies are starved financially and exist on a hand-to-mouth basis since public support in and out of the United Appeals is not necessarily related either to the efficiency of an agency or the value of the service that the agency provides to the community.

The voluntary health and welfare field and the ability of the public to support it is very much like a mill pond. There should be a stream coming in and going out if the water is to be clean and pure. There is always room for expansion on the banks but if for some reason the outlet becomes clogged, flooding may occur with disastrous results. This is exactly the situation in the voluntary health and welfare field at the moment not only in Nova Scotia but in other parts of Canada. We have witnessed a spectacular growth in the development of health and welfare agencies. The job is not yet completed and we have to develop a great many more voluntary activities in new fields not yet explored if we are to demonstrate effectively what can be done. We also need to do much more in some of the voluntary agencies we now have. This is the in-going stream and it must be strong and well supplied at every source point. Unfortunately, the outlet is clogged and the level of the pond

which is the community's financial responsibility is rising to the point where we are threatened with a flood unless we are able to devise some means of removing the obstruction. To do so means in some cases having government-federal, provincial or municipal—take over certain functions which are now carried by voluntary agencies and in other cases having certain voluntary agencies accept the fact that they have outlived their usefulness. This is the nature of the crisis we face. The worst feature of all is that some dynamic and creative agencies are being frustrated by lack of financial support and the public, not fully comprehending what is happening, lumps the good and the bad together.

THIRD. The third task confronting us—community planning—relates very closely to the one just mentioned. Planning has not been a popular word but it is desperately needed today not only in the area of financing but in the broader area of organization and administration. There is too much duplication and overlapping of effort between agencies with a consequent diminution in the effectiveness of the donor's contribution. There is too much consequent wastage of valuable citizen time in collecting funds and in a great variety of other ways. Unless we contemplate killing the goose that has laid the golden egg and which will lay many more—the long-suffering public—we shall have to consider ways and means of working together in planning our health and welfare responsibilities for the community of tomorrow. We are fortunate in the Halifax metropolitan area in having the Welfare Council of Halifax, an organization primarily concerned with health and welfare planning. We must provide this agency with the necessary resources, financial and otherwise, to do the job required of it. We must also direct our attentions to the wider field of provincial planning if our activities are not to be dissipated, our energies wasted and public support alienated.

Ed. Note:

The first article in a series describing the para-medical agencies and professional organizations in Nova Scotia will be found on page 225.

NOVA SCOTIA'S EXPANDING MENTAL HEALTH PROGRAM

*A Report to the Medical Profession

by

CLYDE MARSHALL, M.D.

Administrator, Mental Health Services

The Mental Health Services in Nova Scotia in recent years have undergone a complete transformation and also a very marked expansion. I am not at all sure that the members of the medical profession as a group are fully aware of what has actually taken place. I am, therefore, very pleased to have this opportunity to make a report to the Halifax Medical Society.

To understand what has gone on, one must realize in the first place that the total orientation of the Mental Health Program has changed direction. Originally in Nova Scotia, as elsewhere in the world, what was offered was largely a hospital service, and not too good a hospital service at that. Now, in line with present day thinking in mental health administration, the orientation is directed toward the patient as he lives in the community. Facilities are being provided close to the patient's home so that he can be seen early and treated at a time when treatment will be most effective. At the same time, the hospital services have been markedly improved, but in the overall plan the hospitals now take second place.

When the Mental Health Services Division of the Department of Public Health was organized in 1947, there were no psychiatrists in the community apart from those located in Halifax and Dartmouth. Hence, if we were to carry out this principle of having patients treated near their homes, it would be necessary to create entirely new mental health services in the community. At the present time, a great deal of this has been done, and I want to report to you just how this came about.

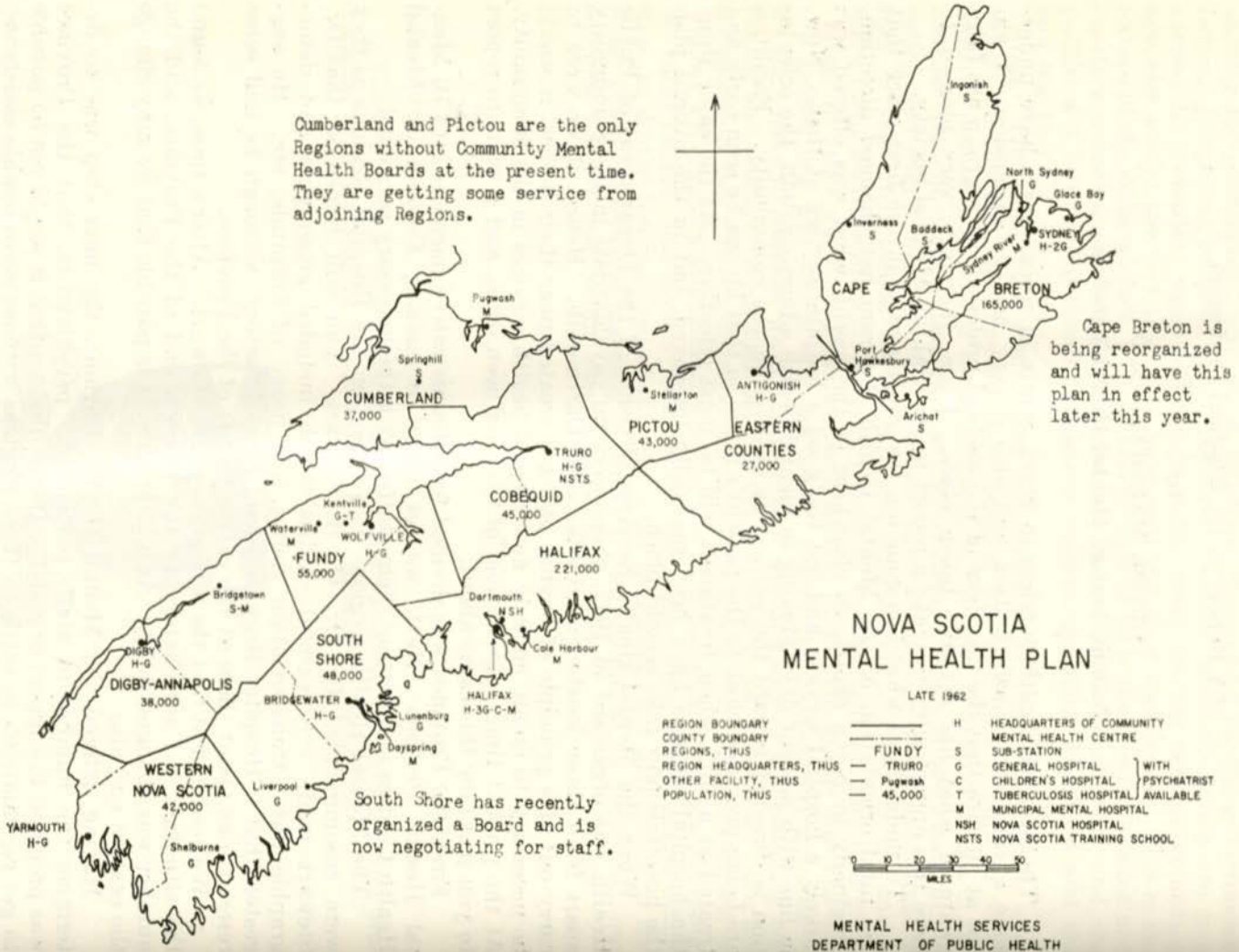
First, the Province was divided for administrative purposes into 10 Mental Health Regions. Next, we set about organizing Community Mental Health Centres and getting them staffed with the necessary personnel.

The Mental Health Regions were based on the Hospital Regions as they were recommended by Dr. C. B. Stewart. You will remember that Dr. Stewart made very careful studies which included geographic and demographic data, transportation routes, the usage of hospitals, etc. He suggested that 9 Hospital Regions would be satisfactory, although he had some reservations about those at the extreme ends of the Province.

We accepted at first the 9 Regions of Dr. Stewart. After a time, we found the situation not satisfactory at the western end of the Province, and the number was changed to 10. At a later date, it is possible that we may change the eastern end also.

Having defined the Mental Health Regions, the next step was to determine the number of staff, particularly psychiatrists, that the Province was prepared to support or assist. It was obvious that it would not be possible to get psychiatrists to settle in these Regions without considerable assistance. The American Psychiatric Association suggested some years ago that there should be at least one psychiatrist in community practice for every 100,000

*Address delivered on April 11, 1962.


Cumberland and Pictou are the only Regions without Community Mental Health Boards at the present time. They are getting some service from adjoining Regions.
Cape Breton is being reorganized and will have this plan in effect later this year.
South Shore has recently organized a Board and is now negotiating for staff.
NOVA SCOTIA
MENTAL HEALTH PLAN
LATE 1962
CUMBERLAND 37,000
PICTOU 43,000
EASTERN COUNTIES 27,000
CAPE BRETON 165,000
COBEQUID 45,000
HALIFAX 221,000
FUNDY 55,000
SOUTH SHORE 48,000
DIGBY-ANNAPOLIS 38,000
WESTERN NOVA SCOTIA 42,000
Springhill S
Pugwash M
Stellarton M
TRURO H-G NSTS
Kentville G-T
Waterville M
WOLFVILLE H-G
Bridgetown S-M
DIGBY H-G
BRIDGEWATER H-G
Lunenburg G
Dayspring M
Dartmouth NSH
Cole Harbour M
HALIFAX H-3G-C-M
Liverpool G
YARMOUTH H-G
Shelburne G
ANTIGONISH H-G
Port Hawkesbury S
Arichat S
Ingonish S
Inverness S
Baddeck S
North Sydney G
Glace Bay G
SYDNEY H-2G
Sydney River M
REGION BOUNDARY
COUNTY BOUNDARY
REGIONS, THUS FUNDY
REGION HEADQUARTERS, THUS TRURO
OTHER FACILITY, THUS Pugwash
POPULATION, THUS 45,000
H HEADQUARTERS OF COMMUNITY MENTAL HEALTH CENTRE
S SUB-STATION
G GENERAL HOSPITAL } WITH
C CHILDREN'S HOSPITAL } PSYCHIATRIST
T TUBERCULOSIS HOSPITAL } AVAILABLE
M MUNICIPAL MENTAL HOSPITAL
NSH NOVA SCOTIA HOSPITAL
NSTS NOVA SCOTIA TRAINING SCHOOL
0 10 20 30 40 50
MILES
MENTAL HEALTH SERVICES
DEPARTMENT OF PUBLIC HEALTH

of population. In recent years, with the increasing usage of psychiatrists, this quota has been found to be too low, and the present recommendation is one for every 50,000. This number was recommended by the Joint Commission on Mental Illness and Health in the United States in 1961.

The Mental Health Services looked at this recommendation carefully to see how it could be applied to Nova Scotia. The Province has a population of 721,000 of which 221,000 are in the Cities of Halifax and Dartmouth and Halifax County. The remaining 500,000 are in the rest of the Province.

Within the Halifax area, there were a number of psychiatrists attached to the University, in private practice and in the out-patient departments of hospitals. No quota based on population was established, but one psychiatrist was authorized for the Halifax Mental Health Centre for Children.

Outside the Halifax area the Joint Commission's recommendation was accepted, that is, one psychiatrist for 50,000 population. Actually, the quota set was 12 psychiatrists for the 500,000 people in this area which works out to be one psychiatrist for every 42,000 population.

No other province in Canada has made such a formal commitment. Perhaps one should except Prince Edward Island where, with its population of 105,000, two psychiatrists would cover the field.

The Regions in Nova Scotia with their population and quota of psychiatrists are shown on the following table. The boundaries of the Regions are shown on the map.

Regions	Population	Authorized Quota of Psychiatrists
Cape Breton	165,000	3
Eastern Counties	27,000	1
Pictou	43,000	1
Cumberland	37,000	1
Cobequid	45,000	1
Fundy	55,000	2
Digby-Annapolis	38,000	1
Western Nova Scotia	42,000	1
South Shore	48,000	1
Halifax	221,000	1

Having defined the Regions, the next question was how should the Mental Health Centres be set up?

Now the general pattern of Mental Health Centres across Canada is for them to be operated directly by government departments. We disliked this for a number of reasons which I need not go into now. We preferred a clinic organized, set up, and controlled by Community Mental Health Boards not markedly different from the way that general hospitals operate. This was to be our plan. We did, however, make one exception in that we supported the Halifax Mental Health Centre for Children. This is operated by the City of Halifax under Dr. A. R. Morton. An Advisory Board consisting of Dr. Jones, Head of the Department of Psychiatry, and myself as Administrator of Mental Health Services was set up with Dr. C. B. Stewart, Dean of Medicine, sitting in. This Centre was established in its present form in 1954.

Our first true Community Mental Health Centre was opened in Wolfville in 1955. This is the Fundy Mental Health Centre. Since then, there has been a new centre opened each year with the exception of 1956. Now, there are 7 Centres in actual operation in the 10 Regions. A new Mental

Health Board was organized in the South Shore Region in March of this year and is now looking for staff. Only two Regions, Cumberland and Pictou, are not organized at the present time. There is, however, considerable activity in Cumberland.

Perhaps we should now look at the way the Boards are set up. They range in size from 10 to 24 members with in some instances an Advisory Group in addition. The local Branch of the Canadian Mental Health Association appoints a number of members for they now play a prominent role in enlisting community support. The medical profession is represented on every Board for we insist that the local practitioners must not only be informed about what is going on, but they must be involved in all the planning. The Public Health Department is represented by the local Health Unit Director. The remainder of the Board members are chosen in different ways depending on the community. Where a university is present, as in Wolfville and Antigonish, and of course Halifax, they are represented. In others, the clergy, general hospital boards, and representatives of towns and municipalities may be represented.

The medical profession has been represented on all of the Boards. In the Fundy Mental Health Centre, Dr. M. R. Elliott was an important influence from the beginning; Dr. G. D. Denton is now the president of the Board; Dr. E. Hiltz and Dr. G. M. Smith have both been active. In Digby, Dr. J. R. McCleave was Board president until recently. In the Western Centre, Dr. J. T. Balmanno has been active. In Cobequid, Dr. B. D. Karrel; in Eastern Counties, Dr. T. W. Gorman, and in Cape Breton, Dr. A. W. Ormiston and Dr. C. A. MacDonald have all been important figures. The interest of the medical profession have been well taken care of by these physicians.

The Boards are required to carry out as comprehensive a mental health program as is possible with the facilities available. A conference was held in Halifax in May 1961 with senior representatives from all the centres. The services to be provided were agreed to include the following:

1. Service to patients
2. Service to organizations, agencies and professional personnel concerned with mental disorder and mental health
3. Education in mental health
4. Prevention
5. Research

Each Board decides how it will carry out the program in its own area, and also determines what other things it wishes to do. The Mental Health Services must agree to the program proposed by the Boards as long as it is in accord with the general frame of reference laid down. This means that the local Boards really control policy.

Now it is obvious that these Community Boards could not function unless they received very considerable financial assistance from the Province.

Actually the Province pays from 80 to 90 per cent of the total costs. It reimburses the Boards for certain specified items, such as salaries for an approved number of staff, travel, office equipment, professional equipment and supplies. The local Boards provide the space required with heat, light, water, telephone and office supplies. The amount of the provincial contribution is greater in Nova Scotia than in certain parts of the United States where Community Centres are supported.

An example will show the extent of the financial support. Last year, the Fundy Mental Health Centre had on its staff two psychiatrists, one psychologist, one social worker, and the necessary secretarial help. It cost approximately $45,000 to run. The Province paid $42,000. The Board raised $5,000 putting $3,000 of this toward operating expenses and setting $2,000 aside for a building fund.

This group will no doubt be interested in how the psychiatrists are paid. They are employed by the Board and are paid by them. They are not Civil Servants. The Province reimburses the Board for salaries at Civil Service rates for Civil Service hours. The Board may grant additional funds if it wishes, but these must come from its own resources. All the Boards grant the right of private practice for hours over and above those specified by Civil Service regulations.

Let us now look at some of the activities of the Mental Health Centres. The *Fundy Mental Health Centre* in Wolfville now operates in a new building which they constructed on the grounds of the Eastern Kings Memorial Hospital. They see most of their patients in the clinic building, and admit a small number to the Eastern Kings Memorial Hospital. They are on the staff of the Blanchard Fraser Memorial Hospital at Kentville and see patients on request. They visit the Nova Scotia Sanatorium at Kentville regularly and provide service to patients, and lectures to students. They visit the Kings County Hospital at Waterville examining all the patients on a regular basis, and providing consultative service in addition. They provide some service to Acadia University. They also meet with the staff of Children's Aid Societies of Wolfville and Windsor on a regular basis. They have a special project for graduate students in theology outlining mental health principles. They participate in the followup program of the Nova Scotia Hospital on terms discussed with and agreed to by the Valley Medical Society. A staff member comes to the Nova Scotia Hospital on a monthly basis to see the patients from that region so as to keep up continuity of care. They participate in teaching programs for Public Health Nurses, Doctors, and others. In other words, they have a full time job.

Last year, they had 302 new referrals and 160 continued from the year before. Of the new referrals, 35 were psychotic, 106 psychoneurotic, 131 had disorders of character, behavior or intelligence, and there were 30 with other diagnoses. Of the 302 new referrals, only 11 were transferred to a mental institution.

Time does not permit me to discuss in detail the activities of the other Community Mental Health Centres. All I can do is mention some of the features of these which are different from what goes on in Fundy.

Cape Breton is now in the process of reorganization. It formerly had two psychiatrists and is now authorized to obtain three. One has already been obtained though not yet in Sydney. It is expected that the remaining appointments will be made soon. The Cape Breton Centre will provide service to the City of Sydney Hospital and St. Rita both in Sydney; to St. Elizabeth's in North Sydney; and to at least one of the Hospitals in Glace Bay. One of the psychiatrists will spend two days a week at the Cape Breton County Hospital. A travelling clinic will be set up to visit other places on the Island including Baddeck, Inverness, Arichat, etc.

The *Eastern Counties Centre* has been given space for its headquarters by St. Martha's Hospital, and the Hospital has also provided a 10 bed ward. Since there is no Mental Health Centre in Pictou, the Eastern Counties Centre is providing a service to the Pictou County Hospital at Stellarton.

The *Cobequid Mental Health Centre* has its headquarters in Truro. In addition to its regular duties, it provides a consultative service to the Nova Scotia Training School. The general hospital in the area is going to be enlarged, and the Mental Health Centre has convinced the Hospital Board of the need for a psychiatric unit in the new addition.

The *Digby-Annapolis Centre* has its main headquarters in Digby, and also has a substation in Bridgetown. It provides service to the Digby General Hospital in Digby and to the Annapolis County Hospital at Bridgetown.

This Centre has an unusual program for assistance to communities which are socially disorganized. This project arose out of the original research in social psychiatry conducted by Cornell University and supported by the Province some years ago.

The *Western Mental Health Centre* has its headquarters in Yarmouth. It also has a substation in Roseway Hospital in Shelburne which it visits once a week. This Centre has an extensive home visiting program.

The *South Shore Centre* has as yet no staff. When these are on duty, it will have its headquarters in the Dawson Memorial Hospital in Bridgewater, and will visit the Fishermen's Memorial Hospital at Lunenburg, and the Queens General Hospital at Liverpool on a regular basis.

The *Halifax Mental Health Centre for Children* you know well. Recently the staff has been increased in order to provide more service to retarded children.

This summarizes the kind of service provided by our Community Mental Health Centres. The comprehensiveness of the plan is unique in Canada, and no other province has anything to compare with it. It has achieved wide acclaim wherever it has been presented. This part of our program is one of which you might well feel proud.

Let us now turn to the kind of mental hospital care that is available in Nova Scotia.

If a patient cannot be treated while he is home either by a private psychiatrist or a mental health centre and needs hospitalization, there are three types of facilities available. These are as follows:

1. Psychiatric services in the local general hospitals
2. The Provincial Mental Institutions—The Nova Scotia Hospital and the Nova Scotia Training School
3. Chronic or Municipal Mental Hospitals located in the community

I want to discuss each of these three facilities excepting that of the Nova Scotia Training School which will have to be left out because of time.

1. Psychiatric Services in general hospitals

In discussing the functions of the Mental Health Centres, I pointed out that the psychiatrists there are all attached to the local general hospital in the region and sometimes to several. It is part of the overall plan for patients to be treated as close to home as is possible. The attaching of psychiatrists to general hospitals is one of the important ways of achieving this aim.

The Joint Commission has made recommendations on this matter as have other important psychiatric bodies. It has been suggested by some that psychiatric facilities be available in all hospitals of 100 beds or over while others say 200 beds or more. Nova Scotia has 14 hospitals of 100 beds or larger if we include the Children's Hospital and the Nova Scotia Sanatorium. When the Cape Breton Mental Health Centre gets reorganized and provides

the service that it has agreed to, 12 of these 14 general hospitals will have psychiatrists attached. In addition, 5 hospitals of under 100 beds have psychiatrists on their staff, and when South Shore gets organized there will be 3 more.

The amount of service given of course varies. In its most limited amount, it simply means a visit on request. At its maxium, it means an independent psychiatric ward. This last is present in only four hospitals—three in Halifax (including the Infirmary which will have its inpatient service soon) and one outside Halifax, St. Martha's in Antigonish.

The attachment of all our psychiatric staff to general hospitals prevents the isolation of these specialists which so often occurs in other places where close relations to general hospitals are not fostered.

This high percentage of hospitals with psychiatrists on staff is a unique achievement. No other province in Canada, excepting again Prince Edward Island, has anything like this number. This is another feature of the Nova Scotia Plan of which you might well take pride.

2. The Nova Scotia Hospital

If a patient needs more intensive treatment of a kind that cannot be provided close to home, either in the Mental Health Centre or in the local general hospital, he may be transferred to the Nova Scotia Hospital. This institution is unusual as far as public hospitals go. Last year it admitted around 1500 patients and had an average of 510 in residence. The great majority of patients are undergoing active treatment, for most of the chronic or continuing care patients are being taken care of in the Municipal Mental Hospitals to be described later.

The Nova Scotia Hospital has undergone a complete reorganization within recent years. A new building, the South Unit where we are now, was opened in 1958. The original building, now called the North Building, has been undergoing modernization with a number of wards being renovated each year. A new nurses' residence of 250 beds has been designed and construction will begin shortly.

But buildings of brick and stone are not enough, and will not make a good program. What has happened to staff? In 1947, there were 5 doctors on duty. The nursing staff considered of 26 nurses and 18 attendants, a total of 44 on the wards. Today there are 17 physicians many of them highly trained including 7 certified. The nursing staff consists of 93 nurses and 228 attendants, a total of 321.

The American Psychiatric Association sets minimum standards for mental hospital personnel. When they are applied to our hospital, these are the figures.

	American Psychiatric Association Standards	On duty
Physicians	13	17
Nurses	69	93
Attendants	114	228

As you see, the number on duty are well in excess of the American Psychiatric Association requirement for these important people. The American Psychiatric Association standards are in fact much too low, and we have had to employ a considerably larger number in order to provide the kind of service

we want. For comparative purposes, it should be pointed out that there are very few public mental hospitals in the United States or Canada which even come up to the American Psychiatric Association Standards.

For psychologists, we are at the American Psychiatric Association level, for social workers, modestly below it, and for registered occupational therapists, very much below.

The total number of staff employed is over 700 for a patient population of a little over 500.

The cost of running a hospital of this type is high. Last year the operating expenses were $15.10 per patient per day. Capital costs and depreciation are not included. Since the Hospital has a number of chronic as well as acute cases, the cost of treatment in the active treatment section is no doubt well above the $15.10 mentioned. It is probably not markedly different from the cost of treating a patient in a good general hospital in the Province.

Apart from buildings and staff, there have been a great many other changes in recent years. We have time to mention only a few.

The Hospital has a number of open wards in which patients can come and go as in a general hospital. The number of wards of this kind are increasing as the hospital gains experience with them. Not all mental hospital wards can be opened. There are still a number of potentially dangerous patients who cannot be left to wander at large.

The Hospital is encouraging voluntary admissions. It is hoped that the number of patients who need to be committed will be markedly reduced, and that most patients will have the same freedom to enter and leave the Nova Scotia Hospital as they do the Victoria General Hospital.

The Hospital has recently been subdivided into two separate units each with its own separate staff. This is in line with the current trend of breaking down larger hospitals into smaller divisions to obtain more personal care.

The Hospital has always been adding to its methods of treatment as new ones are devised. The most recent addition has been the use of newer techniques of group interaction in the day to day management of a ward. This appears to be a real addition to our treatment methods.

Dr. Poulos, the Clinical Director, was sent by the Department of Public Health for a six-month period to England and the Continent to study the newer methods in use overseas. We are now applying such parts of the information he brought back as can be wisely used in the Nova Scotia Hospital.

The Hospital is involved in training programs of many kinds. For many years, there has been a training school for under-graduate nurses. Recently the Hospital has increased the number of nurses which it accepts from other hospitals which affiliate with it. When the new nurses' residence is complete, a training program will be made available for all nurses in the Province so that they can become proficient in psychiatry.

The Hospital has recently undertaken a training program for the provincial public health nurses and public health physicians. All of these personnel in the Province will be trained, and through them we are hoping to get increased mental health services in the community as a whole.

The Hospital has also undertaken a training program for municipal hospital staffs. A short course for hospital superintendents will be given in May, and a number of Municipal Hospital attendants and nurses are being trained in a new technique called "remotivation".

An out-patient department is being started as a followup clinic. It will be extended in the near future to a full and complete out-patient department.

A night centre has been established in a very small way. A night centre is a place where patients can stay at night while they work in the community during the day. The Hospital now does this for a number of patients who are being rehabilitated. They are allowed to sleep in the Hospital until they get adjusted to their jobs, and the pay cheques start coming in. Facilities are planned for enlarging the night centre and for the addition of a day unit. This last is a facility where patients can get the benefit of hospital facilities during the daytime but can return to their own homes at night.

Finally, plans for a Children's Unit are being worked on.

In summary, the Nova Scotia Hospital is without doubt one of the finest public mental hospitals in Canada and for that matter in the United States also. If you don't believe me, ask some of the psychiatrists who have come on the staff after working in mental hospitals in other parts of Canada and the United States. I would refer you to Dr. Young, Dr. Almudevar, or Dr. Destounis.

3. Municipal Mental Hospitals

We now come to a discussion of our Municipal or County Mental Hospitals, our institutions for chronic or long term care.

Patients get into these institutions in one or two ways.

1. Most are admitted by transfer from the Nova Scotia Hospital. These are patients who in spite of intensive treatment remain in a chronic state and who are not well enough to be returned to the community.

2. A smaller number are admitted directly. These are patients who will not benefit by admission to the Nova Scotia Hospital but who need hospital care. These are mainly senile patients or patients with mental defect. All direct admissions must be approved by the Inspector of Humane Institutions.

Now these Municipal Hospitals have had an interesting history. Dr. A. P. Reid, who was Superintendent of the Nova Scotia Hospital in1879, was concerned about the increasing number of patients who were being admitted to the Nova Scotia Hospital where there were insufficient facilities. He suggested a number of ways of dealing with the increasing number, and one of his proposals was what he called the "County Cottage Hospital System". These cottages were to be small institutions located close to the patients' home in good farm land where there would be plenty for the patients to do. They should be under the care of a competent person and his wife, and the local physician was to provide the medical service. No one was to be admitted to these cottage hospitals unless they had been seen first at the Nova Scotia Hospital, and in the opinion of the Superintendent could benefit by this kind of care. He even suggested that the small hospitals might well function as "half-way houses for convalescents".

These cottage hospitals were approved, and by the beginning of the new century, there were quite a number in operation. Unfortunately, they failed miserably for two main reasons. The first was a lack of money, for the county authorities ran them as cheaply as they could. The second was a lack of understanding and vision. The many criticisms that were leveled against these institutions in the past were, as I have documented in another place, fully deserved.

In 1955, the Mental Health Services became responsible for inspecting these institutions although it had no real control over them. A determined effort was begun to improve them. Obviously more money was needed, and

the most likely source for this was the Provincial Treasury. The Province agreed to provide financial assistance but only to those institutions which were prepared to improve their facilities and to meet certain standards.

A set of standards was drawn up by the Mental Health Services, and after considerable discussion were agreed to by the Union of Municipalities. The amount of Provincial assistance to be given was at first one-third of the net operating cost, and this was later raised to one-half.

The standards required that mentally ill patients be completely separated from welfare patients. The Boards of Management of these institutions are to include a number of provincial appointees in addition to those appointed by the counties. A Board of Visitors of five persons is to be appointed, two of whom must be women. This Board of Visitors is to report to the Mental Health Services directly as well as to the Municipal authority. A hospital physician must be appointed who will visit the institution five days a week, and must communicate by telephone on the remaining two days. His general duties are defined. There must be one registered nurse for every fifty patients, and one ward staff member for every six. The space available for patients, not only bedroom space but living room quarters as well, must conform to Federal standards and there must be no overcrowding. Perhaps we should note at this point that the Victoria General Hospital could not qualify under this regulation at the present time nor could many other general hospitals in the Province either! The standards of fire protection must conform to the regulations of the Fire Marshal. Food services are to meet the standards of the Provincial Nutritionist. And there are a number of other requirements.

While these standards were being drawn up, a complete examination of patients in the Municipal Mental Hospitals were undertaken by competent psychiatrists, and many reclassifications were made. Those patients who could get along in Municipal Homes were transferred, and those who might get along in the community were discharged on trial. Others who needed mental hospital care, but who had not been committed, were committed and sent to mental hospitals.

In 1955, there were 17 Municipal Institutions housing mentally ill patients. Five of these cared for the mentally ill alone, while the remaining 12 were mixed institutions caring for both mentally ill and welfare patients.

After the reorganization took place, the number of institutions authorized to accept psychiatric patients was reduced to 9. These became Municipal Mental Hospitals, and continued to be inspected by the Department of Public Health. The remainder were either closed or designated as Municipal Homes, and the inspection of these was transferred to the Department of Public Welfare. This second group will no longer concern us here.

Inverness was the poorest of the 9 mental hospitals, and this institution was later closed thus bringing the number down to 8. Four of the 8 agreed to meet the new standards and became approved institutions. The remaining four did not and are still unapproved. This is how they stand today.

Approved Mental Hospitals	**Population**
Halifax Mental Hospital	324
Halifax County Hospital	535
Cape Breton County Hospital	506
Kings County Hospital	162
Total	1527

Non-Approved Mental Hospitals	Population	
Pictou County Hospital	161	
Cumberland County Hospital	167	
Annapolis County Hospital	58	
Lunenburg County Hospital	205	
Total		591
Total patients in all Municipal Mental Hospitals		2118

Thus it can be seen that 1500 out of the 2100 patients now in Municipal Mental Hospitals are operating under the approved plan. As I mentioned earlier, approval does not mean that these institutions are necessarily up to the standards today, but that they have contracted to meet the standards within a reasonable time.

The approved institutions had to do a lot to become approved. Let us look at a few. The Institution in Halifax, the Old City Home on South Street, contained both mentally ill and welfare patients, and hence could not be approved until the two groups were separated. The City purchased the old hospital at the north end of Gottingen Street, and turned it into the welfare institution now called Basin View Home. Halifax County also had to purchase a new building to separate the welfare group from the mentally ill. It obtained an old army hospital at Eastern Passage and transformed it into the present Ocean View Home. The Kings County Hospital did not have a mixed population, but it did have great overcrowding. To overcome this, a very modern type of a mental hospital was designed and is now being built at Waterville. This new facility will be opened later on this year.

All of the approved institutions had to take on a large number of additional staff. The Cape Breton County Hospital in 1957, at the time of the inquiry by a Royal Commission, had one nurse and 36 attendants on duty. Today the superintendent is a graduate nurse, there are 10 other graduate nurses and 80 attendants. The Halifax County Hospital has 18 graduate nurses, and 94 attendants. Many of the latter are certified nursing assistants. All of the approved institutions have hospital physicians visiting 5 days a week, and on call at other times. The Halifax County Hospital has one physician full time and one half-time.

Some of these hospitals have opened a number of their wards. The Halifax County Hospital is about two-thirds open, and the Cape Breton County Hospital has the first floor of the new building open. The Cape Breton County Hospital has taken off the bars from the old building.

Occupational and activity programs are well under way. One institution has a registered occupational therapist, and another has a trained occupational therapy assistant. All have very active volunteer programs sponsored by the Canadian Mental Health Association.

Thus these four approved institutions have progressed rapidly from their former state.

The four non-approved institutions have not advanced so far, although they have made significant gains. The services of the attending physicians have been increased, and in all cases additional ward staff have been added. The Pictou County Hospital, for example, has increased the visiting schedule of the attending physician from one day a week to five days a week, and has also increased the number of ward attendants from 10 to 23 during the last

year. Some of the four non-approved hospitals still have a considerable distance to go. Lunenburg remains the only institution which houses both mentally ill and welfare patients in the same building although these are in separate wards.

Two very important questions have to be answered. What kind of psychiatric care do these patients get, and what do they need?

When the reorganization first got underway, there were few psychiatrists available, and the amount of service that could be spared for the Municipal Mental Hospitals was not very great. It was arranged first that a psychiatrist from one of the Mental Health Centres in existence at that time or from the Nova Scotia Hospital would visit the Municipal Mental Hospitals once a year and make a complete examination of each patient. He would also make definite recommendations. These might be: 1, that the patient be transferred back to the Nova Scotia Hospital for either additional study or treatment; 2, that changes be made in the treatment program being carried out in the institution where he was; 3, that he be discharged on trial if a suitable place could be found; or 4, that no change be made. A careful followup system was instituted to make sure that the psychiatrists' recommendations were carried out. It will be noted that these psychiatric evaluations were made on all patients in all institutions whether the hospital was approved or not.

When more psychiatrists became available, it was possible to increase the service given to the Municipal Mental Hospitals. The schedule of visits is now as follows:

In the Lunenburg and Cumberland Regions where there are no mental health centres, the hospitals are visited by Dr. Townsend from the Fundy Mental Health Centre once a year.

In Pictou, there is no mental health centre; however, it has been arranged that Dr. Murphy from the Eastern Counties Mental Health Centre will visit the Pictou County Hospital once a month.

The Annapolis County Hospital is supervised from the Digby-Annapolis Mental Health Centre, and the Kings County Hospital from the Fundy Mental Health Centre twice a month.

The Halifax Mental Hospital and the Halifax County Hospital are visited by Dr. Young from the Nova Scotia Hospital on a weekly basis.

When the Cape Breton Mental Health Centre is reorganized this summer, it has agreed to visit the Cape Breton County Hospital twice a week.

As more mental health centres become developed and more staff become available, those institutions on the less frequent schedules will of course get more.

The day to day care in these institutions is the responsibility of the regular hospital staff,—the superintendent, the visiting physicians, matrons, nurses and attendants.

This answers the first question, how much psychiatric care do the patients get? The second question is how much do they need? This one is not easy to answer in spite of its apparent simplicity.

One answer is that the patients need constant psychiatric care and that a psychiatrist should be available in each institution all of the time. These institutions are hospitals, so the argument runs, and what kind of hospitals can they be without a full-time psychiatrist for treatment and supervision.

The first thing to be said about this opinion is that one of the best known and most respected of Britain's Mental Hospitals, the Mapperley Hospital in Nottingham, entrusts the day to day care of its chronic population to gen-

eral practitioners. The psychiatrists in the Hospital spend most of their time with the acute cases and make only periodic rounds on the chronic wards.

Another point to be noted is that the Tyhurst Committee of the Canadian Mental Health Association, set up specifically to make recommendations for mental health facilities for Canada, has this to say: "A great deal of psychiatric time is being wasted in the care of the aged and of long term patients who might just as well be looked after by general practitioners and by occupational therapists with psychiatrists providing part time consultation services."

Still others will argue that hospital type services are not necessary for the great majority of the long term mentally ill, and that better arrangements can be made. Holland and Belgium use fewer hospital facilities than we do, and board out in the community many patients of the kind that we care for in Municipal Mental Hospitals. Further, the British Ministry of Health announced about a year ago that it hoped to reduce the mental patient population of Britain by about 50 per cent in 15 years. Much of the present hospital care will be replaced by home care.

The most ambitious attempt to reduce long stay mental hospital beds that I am aware of on this side of the water is being tried in Colorado. Here a new mental hospital, Fort Logan, is being built to care for about half of the State's population, the 855,000 people who live in Denver and the counties surrounding it. By standards in current use, it would be necessary to provide 3 to 4 beds per thousand of population for the mentally ill, and this part of Colorado would need around 3,000 beds. At the present time, they are building only 391 beds, and are hoping that this will be adequate, although they are not sure. It should be pointed out that they have no backlog of chronic patients, and they are hoping by adequate treatment "to prevent a build up of chronic hospital population". If this could be done in Nova Scotia, there would be no Municipal Mental Hospitals at all and even the size of the Nova Scotia Hospital might eventually be reduced.

What can we make out of all this conflicting opinion? Perhaps we should look first at the patients themselves, and find out what types of illnesses they have.

The patients belong largely to three separate groups:

1. Adult mental defectives, for whom no curative treatment is available.
2. Geriatric cases where the psychiatric problems could be dealt with by a psychiatrist and could also in many cases be dealt with by a good general physician interested in geriatrics.
3. Schizophrenics with varying degrees of activity and chronicity. Some of this group can be greatly helped by good psychiatric care, and some, unfortunately, with our present lack of knowledge, cannot.

All three groups can benefit by good social care and by well planned occupational and activity programs.

The kinds of facility that these patients need can also be grouped into three categories which cut across the diagnostic lines. These are:

1. True mental hospital care which requires an adequate psychiatric staff.
2. Psychiatric nursing care, a lower level form of therapy which should be supervised by psychiatrists but needs less of the psychiatrists' time.
3. Facilities for sheltered living. This should be organized on sound mental health lines, but the need for active psychiatric treatment in the ordinary sense is minimal.

Two observations might be made at this point. The first is that in spite of the generally unfortunate position of many mental health programs compared with those for the physically ill, there is at least some place for long term mental patients to go. I am constantly being requested to admit patients with chronic physical illness to Municipal Mental Hospitals. The physicians in charge of these patients try to magnify a minor mental aberration into a psychosis, simply because they are at their wits end, and can find no other place where the patients can go. Nova Scotia is extremely short of facilities of all kinds for chronic physical care as all of you know.

The second observation is that perhaps we have been unfortunate in our naming of these chronic mental institutions. In order to stress the medical needs of the chronic mental patients, we have abandoned the old word "asylum" which had fallen into disrepute, and have used the nice word "hospital" instead.

Yet these institutions, as I have indicated above, really consist of three facilities,—(1) a hospital, (2) a nursing home, and (3) a facility for sheltered living. When we say "hospital", the word conjures up doctors, internes with white coats, laboratories, and all the other medical paraphernalia. And while these have great value in a true hospital setting, they would not only be out of place but even detrimental in a facility for sheltered living. This last facility which I will call a "sheltered residence" to parallel the well known term "sheltered workshop" should be as small, intimate and homelike as possible.

Mr. Eric Davies, Superintendent of the Halifax County Hospital, is trying very hard to provide just this kind of atmosphere for the group of patients in his care who need this kind of facility. Since his institution is of moderate size and is out in the country, he stresses the fact that he is trying to give this group the benefits of a country club with fishing, sports, croquet, music, drama, television, etc. All power to him!

Ontario in a further elaboration of this idea is now abandoning the use of the word "hospital" and even "patient" in some cases. They have designated certain sections of their hospitals as "residential units" and the patients in them are now called "residents". The operating costs of these residential units are expected to be only a fraction of the cost of the acute active treatment units according to the Ontario Department of Public Health.

But coming back to names, we still have no single word for a facility that is a combination of a long stay hospital, nursing home, and sheltered residence.

The problem is not entirely academic. If a Hospital Insurance Plan comes into effect for the mentally ill, and if the same standards are applied as for the physically ill, a distinction between the three groups will no doubt be forced upon us. It could well be that such an Insurance Plan might cover the first class of patients, but it is doubtful if it would cover the second, and probably not the third.

A final problem about long stay patients is whether they should be cared for in the same institution as the acute treatment cases or in separate facilities. Traditionally, they were together in one big mental hospital. But nobody has a good word for big mental hospitals now, and one of the best features of the Nova Scotia Plan is that we have none of them. But the question still arises for the smaller hospitals,—should the two groups be together or separate?

The Saskatchewan Mental Health authorities have proposed that there should be small mental hospitals of perhaps 300 beds in close relationship to

general hospitals, and that these small hospitals should contain both short term and long term cases. There are to be no ordinary psychiatric wards in the general hospitals themselves in the Saskatchewan Plan.

An opposing view is perhaps best stated by Dr. Jack Ewalt, Professor of Psychiatry at Harvard and Director of the Joint Commission on Mental Illness and Health, which I referred to previously. Dr. Ewalt says:

"It is our considered belief that chronic patients of all sorts require and deserve facilities especially adapted to their particular needs. Special hospitals for special needs insure that every patient has high status. The problem with chronic patients, either in general hospitals oriented to acute medical and surgical programs, or in mental hospitals oriented to the intensive treatment of acute psychiatric illness, is that they are in the way. We push them into back wards. In recent times, and in a few places, pioneers have taken on some of these back wards, but even the most spectacular success stories make little claim that these chronic patients have the highest status in their own hospitals, of which the chronic rehabilitation section is a unit.

"It may be, and we think so, that the needs of long term care differ importantly from those for short term treatment. We believe that one can insure first class care of chronic patients only by planning special facilities for them".

The Nova Scotia Plan follows this line of thought.

Looking now back over our mental hospital program as a whole, it is important to note its flexibility of design. It is so arranged that we can make such changes at a later date as appear after experience to be desired. We have facilities for hospital treatment at three levels—1. The local general hospital in the community, 2. The central institution at Dartmouth, and 3. The long stay hospitals back in the community again. If, for example, it is found desirable to place acute treatment units in Municipal Mental Hospitals, instead of or in addition to, the facilities in the local general hospital, this can be done. These would make the institutions more like those envisaged in the Saskatchewan Plan. If the acute treatment facilities of the local mental health centre and general hospital together can take care of most of the patients in the community and close to their homes, the services of the Nova Scotia Hospital may then be reduced. Finally, if the number of long stay patients now in Municipal Mental Hospitals become reduced, either by more adequate prevention, better treatment, or boarding out programs, the space so vacated can be converted into a facility for the long term care of the physically ill. This kind of facility we desperately need. The Joint Commission on Mental Illness and Health has recommended that there be chronic hospitals taking care of both physically and mentally ill cases in certain instances. To take care of this contingency, it is expected that no new long term mental hospitals will be built in Nova Scotia that are not close to general hospitals.

No mental health program is complete without making provision for the continued treatment or care of the patient after he leaves the hospital. Three separate pilot projects are now underway in Nova Scotia. I have time only to mention them briefly.

The first is the boarding out program. I noted earlier that one large class of long term patients now in mental hospitals needed largely sheltered living. It is obvious that home care, if it could be arranged, would be the most desirable for this group. If the patient could be cared for in his own home, this, of course, is usually to be preferred. But, if he has no home or

his home is unsuitable, a good boarding home is probably second best. Boarding homes have been extensively and successfully used in Holland and Belgium as I mentioned earlier.

We have supported a pilot project in Hants County in which 40 unselected patients were studied, and of this group 12 patients, which is 30 per cent, were successfully placed in boarding homes in the community. The actual boarding out and supervision is under the direction of Mr. Harold Crowell, Director of the Children's Aid Society of the area, the agent for the Municipalities of East and West Hants. The pilot project was arranged in collaboration with the Department of Public Welfare.

The problem in this type of program is to find satisfactory homes and to maintain adequate supervision. We are highly pleased with the progress so far, and the program will be extended as rapidly as adequate supervisory staff for the project can be obtained. If we can be as successful all over the Province as we were in Hants, 630 out of a total of 2100 hospital patients could be returned to the community. However, there remains a very big "if". I noted earlier that the British Ministry of Health hopes to reduce its hospital population by 50 per cent, but some in England doubt if this much can be achieved.

The second project has to do with the after care of patients discharged from the Nova Scotia Hospital. A pilot study on this matter is being made in Kings County. I discussed this matter with the Valley Medical Society inquiring of them what role they felt the Fundy Mental Health Centre at Wolfville should play in the after-care plan. It was felt by the local physicians that the patient should not be referred to the Fundy Mental Health Centre on discharge from the Nova Scotia Hospital on a regular basis. It was agreed that the social worker from the Centre would visit the Nova Scotia Hospital at regular intervals, and keep in touch with all the patients from Kings County. She is also to keep the family and the family physician informed of the progress of the case. When the patient is discharged, the family doctor is to decide how the after care will be handled. If he wishes to do it himself, that is fine; if he wishes the Fundy Mental Health Centre to take over, this can be arranged.

The policy to be adopted in other areas is to be explored by the local Community Mental Health Centres and the local Medical Societies.

The third project has to do with the public health personnel. These personnel have traditionally been involved in Tuberculosis control, school health programs, immunization clinics, etc. It has been agreed that they will extend their services to certain aspects of the mental health field, and that a relationship will be established between the public health units and the community mental health centres. What functions the public health personnel should actually take on will be discussed at a conference to be held in May. The medical profession will, of course, be consulted.

This completes my discussion of the service elements of the Nova Scotia Mental Health Plan. There are many other elements as well—training programs, education, research, etc., but these will have to be left out at this time.

What I wanted to put before you tonight was some of the more important features of Nova Scotia's many sided program. These include the wide coverage and unique nature of the community mental health centres, which have received wide spread and favourable attention in both Canada and the United States; the hospital system on three levels; the large number of gen-

eral hospitals with psychiatrists on staff; the unusually fine features of the active treatment program of the Nova Scotia Hospital; the many changes that have taken place in the Municipal Mental Hospitals in recent years and how these institutions are being modified and improved in the light of modern concepts of long term care; and finally our three pilot projects on the care of patients discharged from mental hospitals.

This is Nova Scotia's expanding mental health program. This is my report to the medical profession.

SAFETY BELTS IN CARS

To: The Editor, The British Medical Journal.

Sir,—Recently I was involved in a road accident in which my car skidded off the road on black ice and overturned three times. Fortunately I escaped with little more than a shaking. As an orthopaedic surgeon at the receiving end of an accident, I thought my colleagues would be interested in the following observations.

I was wearing a full harness, and it was amazing, even when the car was rolling over, how safe I felt. I cannot understand how the harness did hold me vertically in the seat, but it did do so. On the third roll the car roof came in, as it were, and it was only then that I hurt my neck, and this was only a sprain injury. I had no other injuries.

Living near the Great North Road, I see a very large number of the smashed cars of my patients. A day after my accident a patient was admitted, and he died from a very severe dislocation of the atlas on the axis. With interest I inspected my late patient's car and I found it was not very badly damaged, but he was not wearing a harness. I have yet got to see a serious injury in a patient who is wearing harness. In over two decades of busy hospital life I have not yet seen anybody who was burnt to death in a motor-car accident, so I believe the "tying-in" theory is false. The following are my observations:

(1) Full harness is essential. This could well be modified so that the person is held firmly in the seat to prevent him from moving towards the roof and so injure his neck.

(2) I believe that every car should be reinforced in the door pillars, just behind the driving seat. This reinforcement should take the place of a very strong girder hoop, similar to the type which the racing drivers have. I believe that this addition would prevent the roof of the car from caving in during the roll-over type of accident.

I hope this letter may help to convert some of my colleagues who feel doubtful about having harness in their cars.—I am, etc.,

The Memorial Hospital,
Peterborough, Northants. NOEL SMITH.

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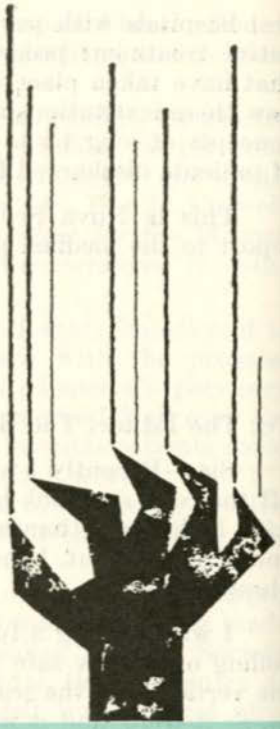


MODERN TREATMENT ON ACNE

HOWARD I. GOLDBERG, M.D.

Halifax, N. S.

Since this is one of the commonest dermatological problems, it warrants the concentrated attention of the family physician or general practitioner, to whom this article is directed. No longer should the adolescent be told that "he or she will grow out of it", but rather be encouraged and to show optimism and perseverance in treatment. The unsightliness of an active case or the resultant scars propose a serious cosmetic defect to the young individual and by preventing him or her to attain a goal in the social or business world, may precipitate neuroses.

Treatment is designed to control the underlying pathological changes viz. an over-activity of the sebaceous glands and a hyperkeratosis at the external orifice of these structures. The latter manifests itself clinically as the comedone, the primary acne lesion. It is important to impress upon the patient that results are not always dramatic and that changes in therapy are often indicated.

The following headings are suggested as a guide in the approach to therapy:—

1. CLEANSING OF THE FACE. This simple and inexpensive procedure performed properly can, in itself, do a great deal. The type of soap and frequency of use depends on the sensitivity of the skin. Soap has anti-bacterial, de-greasing and keratolytic effects and so there are special brands available on the market containing germicides, sulphur, salicylic acid, etc.

   Care of the scalp is important, because of the usual concomitant seborrhea, manifesting itself as the dry or oily "dandruff". An anti-seborrheic agent like tar, incorporated in a shampoo, may be sufficient to control this condition. A neglected scalp can retard the improvement of acne vulgaris.

2. Diet restrictions can be over-emphasized to such an extent, that signs of malnutrition may result. It should be stressed to the parent and patient that "dieting" can be dangerous and that it is not the most important phase of treatment. . . . that the prohibited foods are non-essentials to anybody, e.g. cocoa products, dark carbonated beverages, oily foods (peanuts, potato-chips, fried meats, etc.).

   When possible, the physician should take time to discuss these two procedures, diet and washing, with the patient. It may impress the adolescent to change his or her habits at an early age. Ample outdoor activities and "early to bed" are also indicated.

3. TOPICAL THERAPY. This is designed to combat the basic pathology of acne viz. the prevention of the primary lesion, the comedo and the supression of the over-active sebaceous glands. Exfoliative and drying agents such as precipitated sulphur and resorcinol have these properties. Their concentration in the appropriate vehicle, preferably an alcoholic shake lotion, depends on the type of complexion under treatment i.e. brunettes will tolerate a higher concentration than blondes. With the addition of proper tinting this can be made to look like a liquid powder

make-up, thus rendering it cosmetically acceptable for females. Having such a preparation, she will be more prone to discontinue the application of greasy, pan-cake type, proprietary remedies. The patient should be cautioned to avoid applying this sulphur-resorcinol combination on such hypersensitive areas of the face as the eyelids and peri-orbital regions. For its dramatic anti-inflamatory effect, the addition of a cortico-steroid in this type of preparation, is often indicated. Where secondary infection is prominent, an antibiotic cream or ointment may be applied for overnight.

Severe cases often warrant aggressive desquamation. An example of such an office procedure is the application of a dry ice slush (cryotherapy). The frequency of this type of treatment depends on the severity and progress of the case.

Superficial X-ray therapy plays an important but limited role. Rarely is it necessary to expose the affected areas to the maximum amount of radiation. All details of its administration should be carefully recorded and it should preferably be given by the dermatologist, most of whom have the proper type of machine in the office. Improvement is obtained by its atrophic effect on the sebaceous glands. In my opinion, this modality should be restricted to the older age group (late teens or early twenties), when more conservative topical remedies have not been completely successful and a time of life when the patient must be socially acceptable.

Minor surgical procedures may be indicated e.g. the extraction of comedones or the excision of sebaceous cysts. The incision and drainage of purulent cysts may be necessary, even though it creates another scar on an already damaged skin surface. Patients should always be warned against "squeezing" the acne lesions or removing "blackheads".

In recent years, dermabrasion or surgical planing has been successfully adopted for the treatment of post-acne scarring. It is an office procedure that can be performed under a local anaesthesia, but it should be restricted for severe, chronic cases. The patient must not expect a beautiful new complexion, but simply a definite improvement in the existing scars.

4. SYSTEMIC THERAPY. A severe pustular acne may well require protracted antibiotics, usually as a small daily maintenance dose. Recently the sulfonamides have become more popular, but carefully watching for their well-known side-effects. However, either estrogens or androgens might be indicated in cases where there are definite exacerbations in relation to the menses, but this approach should only be used by the physician who is well acquainted with endocrinology. Some authorities promote vitamin A as a useful therapeutic agent. Since many patients attribute their acne to "bad blood", they often feel neglected if their physician does not prescribe an internal medication. Any systemic approach should be given with caution.

The Nova Scotia Chapter
of
The Canadian Foundation for Poliomyelitis and Rehabilitation

The objects of the Chapter are:

(a) The prevention of poliomyelitis.

(b) To assist in the medical, social, and economic rehabilitation of those afflicted with poliomyelitis.

(c) To cooperate with others engaged in the field of rehabilitation.

The objects are implemented in the following manner:

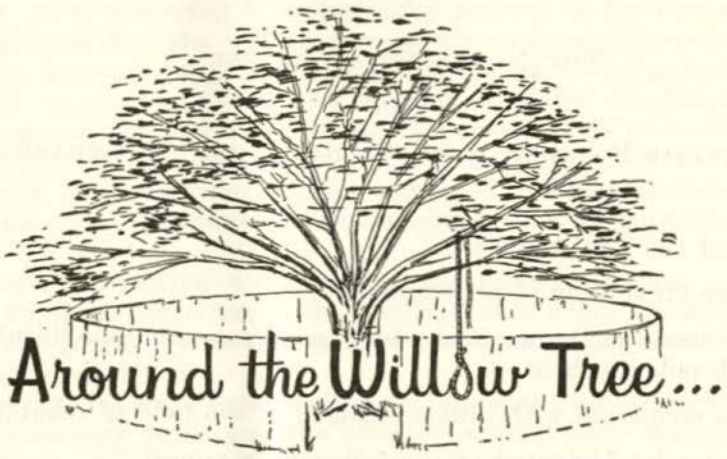
(a) During the years of 1958 and 1959 an intensive three phase inoculation program was conducted in the Province. Since that time the Chapter has participated in considerable public education and public relations programs concerning the necessity for preventative vaccination. The Chapter has stimulated local clubs and organizations to hold polio clinics in their communities.

(b) Orthopaedic Clinics for those afflicted with poliomyelitis are held weekly in Halifax. The complete cost of transportation to and from the clinics is paid by the Chapter, as is also the cost of any appliances or treatments ordered by the clinician. In addition the Chapter maintains a Physical Medicine Clinic in Halifax on a bi-weekly basis and an Orthopaedic Clinic in Sydney on a bi-weekly basis. A travelling physiotherapist is employed to call on polio patients in their home between clinic visits. Two nurses are on the staff of the Chapter to administer the Clinics and to perform necessary social service duties. Complete physical records are maintained on every post-polio patient in the Province. Over the past four years, the Chapter has interested itself seriously in the field of education, at all levels, for those who have been afflicted by this disease. Currently there are children being transported to school and three persons are in full attendance at University.

(c) The Chapter co-operates with all agencies interested in working in the field of rehabilitation by financial contribution, temporary loan of permanent staff and the active assistance of volunteers at all levels.

Briefly, the Chapter provides anything and everything that is required by those afflicted by poliomyelitis, in the field of medical rehabilitation.

In the economic and social rehabilitation field, every reasonable assistance is given to patients. The Directors of the Chapter have shown themselves, at all times, willing to participate with anybody or with any organization in any worthwhile project.



MEDICAL REMINISCENCES

H. W. Schwartz, M.D.

Bedford, N. S.

A Nova Scotian who had lived in the far West for many years was home for a visit last summer and presumably felt qualified to make comparisons, odious though such might be, "You know, the people in the East are peculiar and eccentric," and illustrated her contention by certain amusing incidents and proceeded, "Take yourself, for example," as she continued turning to me, "here you are in your declining years and what do you do? Do you continue to contribute to medical publications from your rich experience, which I am sure would be of interest to the younger men. What do you do but write for a Church paper—outrageous material which no one, old or young, is interested in! Not even the clergy are interested in theology. As Shakespeare had Hamlet say, "The time is out of joint; O cursed spite! That ever I was born to set it right!"

Just to show that I am not as odd as suspected, I propose to indulge in fact and avoid theology, the most fruitful realm of speculation and argument.

Many years ago a woman presented herself, complaining of pain and tenderness very suggestive of mastoiditis. I had an X-ray of the suspected part and was assured by the radiologist that there was no question of the diagnosis. A thorough-going operation was performed, the bone being removed as to expose the inner table, but without being able to demonstrate any evidence of disease. The wound was closed and healing took place by first intention. She was relieved of her discomfort.

Some years later I was treating a patient with a chronically discharging right ear and in a moment of weakness agreed to have an X-ray. So when next day I went to see the film, the radiologist said, "Your patient has a badly diseased left ear." "What did you say—the left side? It's the right side I I am treating, of that I am sure." So he gave me the sound advice, "If you stayed in at night you wouldn't be so confused in the morning," as a teetotaler that couldn't be the explanation. Then and there I called the patient by telephone, who confirmed my claim that I was treating her right ear and further-

more she never had a pain nor an ache in her left. So thus was sown the seed of doubt in my friend's mind, and as I will show, the seed took root. Shakespeare always seems to be able to say what you want to say, but so much better.

> "Modest doubt is called
> The beacon of the wise, the tent (probe)
> that searches to the bottom of the worst."

A thirteen year investigation commenced. One family had fifty-four members, parents, children and grand-children. For our purpose a child had to have had its seventh birthday. Whilst the grandparents were being persuaded to submit to X-ray examination, being convinced the whole performance was silly from end to end, I discovered twenty-nine sets of identical twins and two sets of triplets. The upshot was 564 temporal bones and Dr. S. R. Johnston and I spent evening after evening classifying them as to structure—cellular, sclerotic, or diploic, and our conclusion was that what the roentgenologist sees in his film is probably more closely related to grandparents and the parents than some supposedly old infection.

My part was to round up the patients and Dr. Johnston taught his technician the best positions and the best angles to exhibit the anatomical structure of the mastoid process of the temporal bone.

Securing twins and triplets to come and have an X-ray examination in this area did not involve great effort, as some members of a wanted family had been to see me professionally and were pleased to cooperate.

One twin lived in Halifax, the other in another city, but said she would report to her local hospital whenever the appointment was made. I write to the roentgenologist telling him what Dr. Johnston and I were doing and giving him all the details, etc., but did not receive even a postal card in reply. Supposing he was away, and in one of the services, I addressed the Superintendent of his hospital and was told the roentgenologist was well and had been in daily attendance at the hospital and that he would speak to him personally and ask that he accede to our request without further delay. The films did eventually arrive but obviously the technique that was asked to be observed was disregarded and the films were worthless and had to be destroyed. I had a similar experience in another quarter but with this difference. The Hospital was a Company institution and the material was accompanied by a proper bill, which was of course paid for by return mail, this however can be said, that Dr. Johnston's technique was followed and the result did not have to be thrown out.

A Rev. Doctor of Divinity who had been invited to address a clerical gathering, and his address was refused publication by the Editor (at that time) of the Church paper that served the needs of that particular area and those who had invited him to lecture, told me he was depressed by the apparent lack of interest of clergymen in the subject of theology. It would appear that the men of the scalpel and those of the cloth have some things in common.

The study was a bit tedious. A baby born today would not qualify for examination until on or after its seventh birthday. However, time did pass and the result was presented as my Presidential address before the Canadian Society of Otolaryngology at Digby, Nova Scotia at its Meeting 1950 under the title "The Influence of Heredity on the Pneumatization of the Temporal Bone", and subsequently published in the Journal of Laryngology, May 1951.

You may ask was it worth while spending so many months and tedious hours; no monetary reward, that is sure, but that there was a reward can be judged by a letter received from our own Dr. W. J. McNally of Montreal, an internationally recognized authority in the field of Otolaryngology. He wrote, under date of 13/6/52, "I was at a meeting a month ago at which there were present many of the leading American otolaryngologists. I overheard two of them discussing mastoid bone development. I pricked up my ears, and one of them said that he had just recently read an article written by a man by the name of Schwartz from Halifax on the development of the mastoid bone. He thought that this article was one of the best that he had ever seen on this particular subject.

I pass this along to you because in the course of a day sometimes it cheers one to hear some of the good things that are said."

There are a few odds and ends which were of interest to me and I hope will prove of value to you as I continue to make more rambling remarks about disease involving the ear and accessory nasal sinuses.

I can recall the case of a young man aged 21 being admitted in a desperately ill condition, absolutely prostrate, hardly able to turn his head, with pus pouring from both nostrils and Potts puffy tumour (oedema of the scalp associated with osteomyelitis of the skull bones) over the forehead, the diagnosis of acute sinusitus so severe as to involve the bony skeleton. The operating room was arranged for and a medical relative of the patient, a leading general surgeon of his in this Province suggested an X-ray "to anticipate the patient's friends", so when the patient was practically on the way to the O.R., this was done. On reflection of the scalp, pus oozed from all the area of the frontal bone, the bone well beyond the area of obvious disease was removed exposing the dura mater over quite a large area. The balance of the operation would not be of any interest. Taking advantage of the anaesthesia, the antra were irrigated. Then we went to see the X-ray films—astonishment and amazement are mild and gentle terms. That in the presence of so much disease, films were perfectly normal, no evidence whatsoever that anything was wrong. That such was possible was a valuable lesson to me, it was accordingly the most valuable X-ray film I had ever asked for.

An ambulant patient came to my consulting room suffering from pain and nasal discharge. After I had made the routine examination, common to all otolaryngologists, and told him the diagnosis and what should be done, he turned to me and asked if I required an X-ray. I said no. "Then why did my doctor order one and put me to that expense and why did the radiologist tell me there was nothing wrong."

With these cases in mind I began to look into the literature and learned that my cases were not unique by any means and the unreliability of the X-ray in infection of the ear and nasal sinuses is well recognized on both sides of the Atlantic.

It was crystal clear that the X-ray may be not only worthless as an aid to diagnosis, but may be positively dangerous if any attention is paid to such in the presence of acute inflammatory conditions involving clinically diagnosed disease of the ear or accessory nasal sinuses. Diagnosis is an art in which short cuts have no place.

In otolaryngology the examination has to be carried out in an orderly way and each item valued in the light of clinical experience. A stream of pus presenting beneath the middle turbinate is worth a cartload of X-ray films. The patient may suffer from an allergy giving rise to oedema of sinus mucous membranes. The radiologist should be made aware of such, for after all he is acting in the capacity of a medical consultant, not as that of a magician and should give heed to the words of St. Paul "not to think of himself more highly than he ought to think; but to think soberly" before making unaided pronouncements as to the presence or absence of infection. It is not a matter of placing a penny in the slot, press the button, and out comes the diagnosis.

I may be peculiar and eccentric and entertain the strange opinion that a post mortem examination is an unsatisfactory time to make the diagnosis.

As a result, I prepared an article on the subject which I entitled "How to be Wrong: The X-Ray a Quick and Easy Method", published in the C.M.A.J. May 1940 42: p 450.

The next case, January, February 1944, is I think of some historic interest. Dr. R. H. Stoddard invited me to associate myself with him in the care of a case at the Halifax Infirmary, of osteomyelitis of the skull, secondary to acute sinusitis. The diseased bone was removed far and wide, no halfway measures were considered, the patient went from bad but not to worse, as he didn't develop meningitis. Penicillin was known, but what little existed was reserved for the Services. Dr. Stoddard, a former army medical officer and on the inside track, persuaded the officer who had the say as to who should benefit from this even now relatively scarce remedy, to see our patient. So on March 28th, 1944, all including the Sister Superior stood about with our mouths agape to witness the administration of this miraculous remedy, the first civilian in Nova Scotia to be so treated and the first civilian doctor to preside over its use. The patient responded very satisfactorily and Dr. Stoddard was speaking to him a few days ago (April 1962). Total grant 500,000 units—administered 10,000 intramuscularly every 4 hours—March 28th to April 1st.

We hear the expression "No sir, I will never forget that case." May I be so bold as to make a suggestion, applicable alike to the beginner and the old-timer. The latter may appreciate it more as it is based on experience. No one seems too old to forget—in the course of time the matter becomes a bit hazy, then foggy and after months and years vague to the stage of complete forgetfullness.

A loose-leaf indexed book, the interesting case so fresh and clear at the moment is entered along with any helpful references gleaned from text book, magazine or medical journal.

> That time of year thou may'st in me behold
> When yellow leaves, or none, or few, do hang
> Upon those boughs which shake against the cold
> Bare ruin'd choirs, where late the sweet birds sang.
>
> —Wm. Shakespeare, Sonnet 73

PERSONAL INTEREST NOTES

Halifax Medical Society

May 23, 1962—Dr. W. A. Curry, Halifax, was honoured with senior membership in The Canadian Medical Association during the annual meeting of the Medical Society of Nova Scotia held in Halifax. (Editor's note: As the other activities of the Annual Meeting will be dealt with elsewhere in this bulletin, they will not be touched upon in these notes).

May 17, 1962—Dr. H. B. Atlee, Professor Emeritus of Obstetrics and Gynaecology at Dalhousie University, is to receive a plaque for pioneer efforts in the fields of family-centered maternity and infant care from the International Childbirth Education Association Inc., at the annual convention in Seattle, Washington, June 17-23, 1962. This is the first time the plaque has been awarded.

Several doctors have announced the opening of their offices for general practice:

Dr. J. Arthur Bishop, 221 Victoria Road, Dartmouth—phone 469-1551—(in association with the Dartmouth Medical Centre).

Dr. J. Kempton Hayes, 647 Quinpool Road, Halifax—454-1547—(in association with Doctors F. Murray Fraser and Robert C. Fraser).

Dr. Michael A. MacKinnon, 349 Herring Cove Road, Spryfield—Phone 477-4641—(in association with Doctors Marjorie L. and Kevin P. Smith).

Dr. W. M. MacRae from 647 to 203 Quinpool Road, Halifax—Phone 422-4555.

June 24, 1962—The renovated section of the Halifax Infirmary was opened officially by Most Rev. J. Gerald Berry, Archbishop of Halifax. This will increase the bed capacity from 230 to 480, the total cost of both renovating the old building and the new wing being some $7,200,000. Total building occupancy will be on a gradual basis as staff requirements and administrative considerations permit. With total building occupancy, the teaching agreement with Dalhousie University becomes effective, making necessary the establishment of geographical teaching sections in all clinical departments. The new medical staff, recently appointed, is to have a departmentalized clinical organization that is required of all university teaching hospitals.

The Atlantic Society of Obstetricians and Gynaecologists.

May 26, 1962—28 Doctors attended the Annual Meeting of the Society held in Halifax on Saturday, 23 of whom were members of the Society and the remainder being post-graduate students at Dalhousie University. Clinical sessions were held throughout the morning and afternoon at the Glace Maternity Hospital and included: "Amenorrhoea and Hirsutism" by Drs. Clair MacLeod and Greg Tompkins, a panel on "The Role of the Obstetrician in the future and his relation to the General Practitioner-Obstetrician" moderated by Dr. Carl Tupper, with members of the panel being Drs. Greg Tompkins, Frank Wanamaker, Kenneth MacLennan and John Maloney; and a paper "Suppression of Lactation" by Drs. Robert Wingers and Stuart Robinson. At the business sessions Dr. Frank Wanamaker, Saint John, N. B. was elected the new President. Other officers elected were Vice-President—Dr. John Maloney, Charlottetown, P.E.I.; Secretary-Treasurer—Dr. Donald F. Smith, Halifax; and members of Council are to include Drs. Francis L. O'Dea, Saint John's, Nfld.; J. Kenneth Irwin, Charlottetown, P.E.I.; J. Raymond Boulay,

Campbellton, N. B.; Kenneth M. Grant, Halifax; and W. R. Carl Tupper, Halifax. It was decided the next annual meeting of the Society would take place in Saint John, N. B. on May 25, 1963. A dinner was held during the evening for members and their wives, in the Harbour Suite of the Nova Scotian Hotel, the dinner address "Pre-European Man in Nova Scotia" was given by Mr. J. S. Erskine, Wolfville, N. S., who was introduced by Dr. John Maloney. (Editor's note: we wish to thank Dr. Donald F. Smith, Secretary-Treasurer for these notes).

Royal Commission on Health Services

May 15, 1962—In its brief to the Royal Commission on Health Services in Toronto, the College of General Practice of Canada suggested that a thorough review and revision of the whole medical curriculum is a fundamental necessity. The college felt that the medical curiculum should keep in mind that the general physician has one of the most important roles in medicine, and urged family doctors to play a bigger role in medical education. Sessions earlier in the day were punctuated with clashes between members of the Commission and Doctors presenting the brief of The Canadian Medical Association. At one point, Chief Justice Emmett Hall, of Saskatchewan, told Dr. Joseph A. McMillan of Charlottetown, a member of the CMA seven-man team, that one of his replies was "just another propaganda speech".

Births

To Dr. and Mrs. Robert S. Grant, a daughter, at the Grace Maternity Hospital, Halifax, on May 29, 1962.

To Dr. and Mrs. David Stewart, a daughter, Jennifer Elizabeth, at the Grace Maternity Hospital, Halifax, on May 30, 1962.

Coming Meetings

The director of the post-graduate division, Faculty of Medicine, Dalhousie University advises that the post-graduate division is particularly anxious that all practitioners take short periods of full time post-graduate training, or year long periods of once weekly training by special arrangement with various departmental heads at the University. The director of the division is prepared to assist in making these arrangements not only at Dalhousie, but also is prepared to obtain information regarding opportunities within the Atlantic Provinces.

Sept. 18-21, 1962—Fifth Canadian Conference on Mental Retardation, Nova Scotian Hotel, Halifax. This conference, sponsored by the Canadian Association for Retarded Children, will have as its theme: "The Community—A Necessary Member of the Team". Slogan: "Help Them to Help Themselves". For further information: Mrs. L. J. Stewart, C.A.R.C., National Conference Chairman, 610 Kenaston Ave., Town of Mount Royal, Quebec.

The Department of Anaesthesia and the Post-Graduate Division, Faculty of Medicine, announce a Short Course in Anaesthesia to be held in the Victoria General and Children's Hospitals September 24th to 28th inclusive. Mornings will be spent in the operating rooms participating in anaesthetic techniques, the afternoons in lectures, seminars, and demonstrations. With the aid of a grant to the Post-Graduate Division from Ayerst, McKenna & Harrison Limited a prominent guest anaesthetist and pharmacologist will participate in the program. Advance registration is advisable.

COMING MEETINGS (Cont)

Nov. 28-Dec. 1, 1962—Annual and Scientific Meetings of the Canadian Cardiovascular Society and the Canadian Heart Foundation will be held in Quebec City. Address inquiries to Dr. John B. Armstrong, Canadian Heart Foundation, 501 Yonge Street, Toronto 5, Ontario.

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

Sept. 23-26, 1963—6th Canadian Conference on Mental Retardation, Marlborough Hotel, Winnipeg, Manitoba.

Key and Conwell's Management of Fractures, Dislocations and Sprains. H. Earle Conwell and Fred C. Raynolds. 1153 pages. Illust. 7th. ed. The C. V. Mosby Company, St. Louis, Mo., 1961. $27.00.

This new edition of an excellent book consists of six chapters devoted to principles and general aspects in the management of fractures, dislocations and sprains and seventeen chapters which deal with specific injuries.

In the general section, evaluation of the entire patient rather than of an isolated injury is emphasized, while throughout the book, a practical rather than a theoretical approach to the management of the injuries discussed is put forward and modern trends in management are covered thoroughly.

The chapters dealing with specific injuries offer, in each case a clear and concise presentation of the injury, and examples, profusely illustrated with photographs and X-ray reproductions to illustrate a complete step-by-step handling.

Especially worthy of note is the chapter on hand injuries, a subject that is too often treated superficially in other reference books. Nearly 100 pages are devoted to this important but often neglected subject.

The chapter on facial injuries will also prove especially useful as a source of reference.

Perhaps the greatest value in this book lies in the fact that while it offers a wealth of detail and advanced material, the manner of presentation is so simple that the medical student may select what he needs without becoming involved in discussions of procedures beyond his immediate concern.

Because it combines a complete coverage of the subject material with simplicity of presentation, this book will be valuable not only for the medical student, but for the general surgeon or orthopedic surgeon as well as the general practitioner called upon less frequently to treat a fracture.

M.T.C.