Vol. XLII MAY 1963 No. 5

The NOVA SCOTIA MEDICAL BULLETIN

Editorial

". . . as Strong as Its Weakest Link"

"There is no merit in just belonging to anything. The merit comes entirely through whatever personal effort we give to make the organization function. An organization is not an entity. It has no life and no meaning in itself. It is simply a line of functioning individuals. When one individual fails to function, the whole line is affected. The greatest possible idea that can be put across in relation to any organization is the idea of personal responsibility for corporate action."

The foregoing has been quoted twice in editorials in the Bulletin (1, 2.) On each occasion the Editor was examining the future requirements of the Society to meet the challenge of the business of Medicine as a facet of increasing importance in the physician's responsibility to both the patient and the profession. The desirability and necessity of those pleas has been amply justified in the light of events between 1956 and 1963.

It has been suggested that we again examine ourselves against the background of such progress as has been made so that the Society may proceed with plans to achieve an organization in which the members are more knowledgeable in the business affairs of medicine and to encourage ". . . the idea of personal responsibility for corporate action", the more effectively to cope with the challenge of changing times.

Membership in The Medical Society of Nova Scotia and the Canadian Medical Association is voluntary. Nova Scotia has wisely decided that the strength of membership on the voluntary basis outweighs any advantages of the so-called "compulsory membership". In 1956 there were 398 members in this Society(3). This has increased to 630 as of 1962, which is approximately 80% of the physicians licenced to practice and resident in Nova Scotia. Obviously there is room for improvement and the responsibility lies primarily with the present members to interest their non-member confreres to apply for membership.

What is being done to communicate with our members? There are ten Branch Societies which provide geographic coverage of the province. A system has been developed whereby each Branch Society holds a meeting two to three weeks prior to each Executive Committee meeting of the parent body.

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

MEMBERS OF EXECUTIVE COMMITTEE

OFFICERS

President	D. F. Macdonald
President-Elect	C. L. Gosse
Immediate Past-President	R. F. Ross
Chairman Executive Committee	L. C. Steeves
Vice-Chairman Executive	J. E. H. Miller
Honorary Treasurer	J. F. Boudreau
Executive Secretary	C. J. W. Beckwith

BRANCH SOCIETY REPRESENTATIVES

Antigonish-Guysborough	T. W. Gorman
Cape Breton	D. H. MacKenzie, J. R. Macneil
Colchester-East Hants	H. R. McKean
Cumberland	J. C. Murray
Halifax	F. J. Barton, K. M. Grant, R. O. Jones
Inverness-Victoria	H. A. Ratchford
Lunenburg-Queens	A. J. M. Griffiths
Pictou County	C. B. Smith
Valley	J. A. Smith
Western Counties	C. K. Fuller

OBSERVERS

Representative to C.M.A. Executive Committee	D. I. Rice
Chairman Public Relations Committee	S. C. Robinson
Chairman Medical Economics Committee	H. E. Christie

CHAIRMEN OF STANDING COMMITTEES

COMMITTEE	CHAIRMAN	COMMITTEE	CHAIRMAN
Archives	C. M. Bethune	Medical Education	D. C. Cantelope
By-laws	J. E. Hiltz	Maternal & Perinatal Health	M. G. Tompkins
Cancer	J. E. Stapleton	Membership	J. A. Myrden
Child Health	R. S. Grant	Nutrition	W. A. Cochrane
Civil Disaster	S. B. Bird	Pharmacy	J. E. MacDonnell
Discipline	R. F. Ross	Physical Education & Recreation	J. M. Williston
Editorial Board (Editor)	J. F. Filbee	Public Health	S. D. Dunn
Fees	J. E. H. Miller	Public Relations	S. C. Robinson
Finance (Hon. Treas.)	J. F. Boudreau	Rehabilitation	G. J. H. Colwell
Health Insurance	D. McD. Archibald	Resolutions	L. C. Steeves
Insurance	A. J. Brady	Special Research	A. A. Giffin
Legislation & Ethics	D. F. Smith	Traffic Accidents	A. L. Murphy
Medical Economics	H. E. Christie	W. C. B. Liaison	A. W. Titus

BRANCH SOCIETIES	President	Secretary
Antigonish-Guysborough	G. L. Silver	R. Sers
Cape Breton	N. K. MacLennan	H. R. Corbett
Colchester-East Hants	C. C. Giffin	K. B. Shephard
Cumberland	D. C. Brown	J. A. Y. McCully
Halifax	K. M. Grant	G. J. H. Colwell
Inverness Victoria	H. A. Ratchford	W. MacIsaac
Lunenburg-Queens	F. W. Prince	W. I. Bent
Pictou County	L. M. Sproull	W. D. MacLean
Valley Medical	G. K. Smith	E. G. Vaughan
Western Counties	A. F. C. Scott	G. D. Belliveau

AFFILIATE SOCIETIES	PRESIDENTS
Nova Scotia Association of Radiologists	A. J. M. Griffiths
Nova Scotia Society of Ophthalmology & Otolaryngology	R. H. Fraser
Nova Scotia Society of General Practitioners	A. G. MacLeod
Nova Scotia Chapter of College of General Practitioners	
Nova Scotia Division of Canadian Anaesthetists' Society	C. H. L. Baker
Nova Scotia Association of Pathologists	J. N. Park

The Branch representative to the Executive Committee reports to his Branch and the Executive Secretary or an officer of the Society attends each Scheduled Branch Meeting. Communications and/or resolutions from Branch Societies are presented to the Executive Committee at the subsequent meeting. Supplemented by a News Letter as well as the monthly Nova Scotia Medical Bulletin, this liaison has proved to be advantageous for those who attend Branch meetings.

The Executive Committee is made up of the officers and thirteen representatives from the ten Branch Societies. The Divisional representative to the Executive of the C. M. A., the Chairmen of the Committees on Public Relations, Economics and the Editorial Board of the Bulletin are observers. The Executive Committee has the authority to conduct the business of the Society between Annual Meetings. To fulfil this directive it has four of five Regular Meetings between each Annual Meeting and Special Meetings as required. Between Executive Committee meetings, the Executive Secretary has at least weekly conferences with the Chairman of the Executive, who may consult with the officers of the Society if such is indicated. The Executive Committee, through its Chairman, reports to the Annual Meeting.

The interests of the Society are also served by twenty-six Standing Committees, six Special Committees and representatives to seven organizations. Each Committee functions under a Chairman who *may* report to any meeting of the Executive and who is *required* to report to each Annual Meeting.

It would seem that the total of these efforts should adequately care for the business of the Society. There is no doubt that it is successful to a considerable degree up to the Annual Meeting which leaves much to be desired. The Annual Meeting should be the focus of all members, or their representatives, since that Meeting receives reports on the work of the Society during the current year which are discussed, amended or adopted. From the meeting emanates the policy which the Executive Committee is to project during the ensuing year.

Registration of members at the Annual Meeting is in the vicinity of one hundred. In that number are included the officers and the representatives to the Executive Committee and the guests; thus between seventy and eighty members at large register. However, attendance at the business sessions will average approximately forty. There are those who believe that a voluntary organization depends on twenty percent of its membership and that the art of successful voluntary organization is the ability to identify such members. Twenty percent of our membership would mean a registration of approximately 125 and attendance at each business session of approximately 100.

How can this potential be achieved? It would seem that the factor of personal obligation and responsibility requires strengthening.

An organization cannot expect to have all members attend Annual Meetings, but it can expect to have such attendance as will be representative of its several interests. Such selected or elected representatives would assume an obligation to those they represent as well as to the organization as a whole. The members of the Executive Committee and the officers, who have the obligation to conduct the business of the Society between Annual Meetings, are a geographic distribution of members or a horizontal section of the Society. It should be supplemented by representation in depth at the Annual Meetings.

The first step has been taken in the new By-Laws which permits members

of the Society to make application for recognition as a Section within the Society representing " . . . any particular aspect of the science and /or practice of medicine or related interests . . .". To date nine such Sections have been recognized by the Executive and more applications are expected. This development is confidently expected to be advantageous to both the parent body and the Sections.

There remains the desirability to have a body representative of the medical profession that can be convened at the Annual Meeting which will reflect the views of medicine on any problem and develop policy which will be representative of and accepted by the profession as a whole. Such a body would be a Council of The Medical Society of Nova Scotia.

This concept of a Council has been under consideration for some time. Interest has now developed to the point where the Executive Committee, on the recommendation of the Special Committee on Annual Meetings, has instructed the Committee on By-Laws to report on the concept of a Council, in time for the Annual Meeting, 1963. In general terms there would be approximately ninety members of Council, comprising the officers and members of the Executive Committee, the Chairmen of Committees, representation from Sections, delegates from Branch Societies as well as other selected representatives. Between Annual Meetings members of Council would be kept informed on all matters pertaining to medical interests and at the time of the Annual Session would formulate policy.

Changing times require changing attitudes. The loosely-knit organization characteristic of voluntary bodies must be strengthened for the purpose of presenting views and policy which is representative of thoughtful and informed opinion. To fulfil this the obligation currently assumed by a few must be spread to a greater number. The challenge is there. Can we meet it?

REFERENCES

1. Editorial N. S. Med. Bull. 1956. 35, 272.
2. Editorial N. S. Med. Bull. 1957. 36, 385.
3. Presidential Address. (R. O. Jones,M.D.) 1956. 35, 274.

C.J.W.B.

NOTICE TO MEMBERS

At the meeting of the Executive Committee December 1st., 1962 the following resolution was carried:

"THAT notice of motion be given to the Annual Meeting of The Medical Society of Nova Scotia that practitioners resident in the province of Nova Scotia be required to be members of The Medical Society of Nova Scotia before they can be participating physicians in Maritime Medical Care, Incorporated."

PROVISIONAL PROGRAMME

110th ANNUAL MEETING

THE MEDICAL SOCIETY OF NOVA SCOTIA

Nova Scotia Division, C.M.A.

BRAEMAR LODGE, YARMOUTH COUNTY, NOVA SCOTIA

JULY 2, 3, 4, and 5, 1963

July 1 - Monday DOMINION DAY

9.00 a.m.-11.00 p.m. Western Counties Medical Society invites you to a "CEILIDH" - Welcome to all - this will provide an opportunity to renew acquaintances.
Refreshments will be available.
"Mine hosts", Drs. Rideout and Sutherland.

YOU MAY REGISTER THIS EVENING - REGISTRATION DESK WILL BE AVAILABLE.

July 2 - Tuesday

8.30 a.m. REGISTRATION

9.30 a.m. 1st Business Session.

11.00 a.m. Coffee Break.

11.30 a.m. 2nd Business Session.

1.00 p.m. LUNCHEON

Chairman:

Speaker - A. F. W. Peart, M.D., Deputy General Secretary, C.M.A.

Subject - Progress in the Various Provinces - Medical Services.

2.30 p.m.- 5.00 p.m. 3rd Business Session.

9.00 p.m.- 1.00 a.m. ANNUAL BALL

Featuring entertainment by Bob MacLeod Orchestra.

Music by "The Acadians."

FINAL REMINDER

COME TO BRAEMAR - 110th Annual Meeting

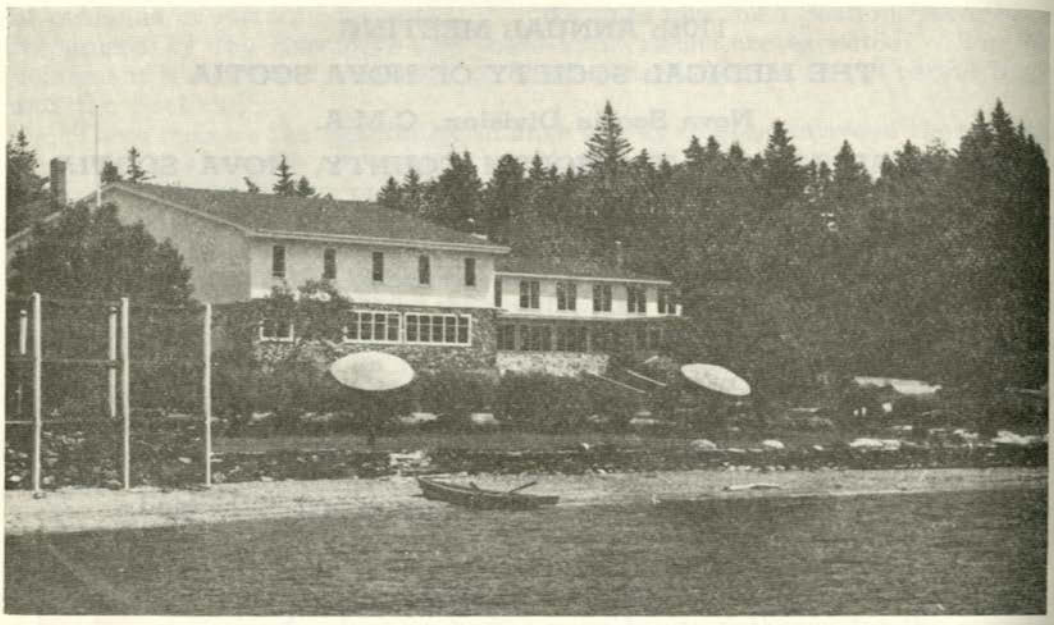

PHOTO BY KEN OXNER

As this goes to press (April 29th, 1963) the final plans are nearing completion for the forthcoming Annual Meeting of The Medical Society of Nova Scotia at Braemar Lodge, Yarmouth County, July 2-5, 1963; July 2 and 3 are for 6 Business Sessions - July 4 and 5 for Clinical Sessions, Social and Sporting events.

Completed Housing Application Forms should be forwarded as soon as possible. Last minute arrangements very often result in disappointment.

Your Committee Chairmen and Executive have been extremely busy in arranging a varied programme and we believe this year's meeting is expected to be most successful.

It is hoped that as many members as possible will attend since the business sessions of the Annual Meeting are the most important in the Medical Calendar. It is from these that policy is formed to guide the Executive Committee in the ensuing year.

The ladies' programme under the chairmanship of Mrs. D. F. Macdonald is a most interesting one. The Entertainment Committee has certainly surpassed itself this year. Don't forget your golf clubs and musical instruments!

YOUR HOST SOCIETY

THE WESTERN COUNTIES MEDICAL SOCIETY

Extends to all members a most hearty welcome and will greet you at

BRAEMAR LODGE - Yarmouth Co., N. S.

G. D. BELLIVEAU,

Chairman, Publicity

July 3 - Wednesday

	REGISTRATION
9.30 a.m.	4th Business Session.
11.00 a.m.	Coffee Break.
11.30 a.m.- 1.00 p.m.	5th Business Session.
	Emphasis on Medical Economics.
1.00 p.m.	Buffet Lunch.
	Chairman:
	Speaker - W. W. Wigle, M.D., President of C.M.A. Subject - (to be announced)
2.30 p.m.- 5.00 p.m.	6th Business Session - Medical Economics continued including Report of Special Research Committee, and a Panel Discussion on "M.M.C. Inc. as a carrier for Medical Services Insurance."
7.30 p.m.	LOBSTER SUPPER
	Lake front near dining area followed by entertainment in dining area.

July 4 - Thursday

	REGISTRATION
9.30 a.m.	Panel on Hypertension.
	Chairman: P. H. LeBlanc, M.D.
	Moderators: Drs. Lot Page and Guy Leadbetter.
10.45 a.m.	Coffee Break.
11.15 a.m.-12.30 p.m.	Panel on Paediatric Urinary Tract Infections.
	Chairman: Ron W. Campbell, M.D.
	Moderators: Drs. Leadbetter and Page.
1.00 p.m.	LUNCHEON - no programme.

AFTERNOON FREE - for Golf, Fishing, Shopping, Drives, Sailing, etc.

7.00 p.m.	President's Reception Annual Banquet. Chairman: Dr. Anthony Scott, President Western Counties Medical Society. Presentation of prizes and trophies.

July 5 - Friday

9.30 a.m.-11.00 a.m.	Clinical Session. (Subject to be announced)
11.00 a.m.-11.30 a.m.	Coffee Break
11.30 a.m.-12.30 p.m.	Clinical Session. (Subject to be announced)
1.00 p.m.	LUNCHEON
	Chairman: Dr. C. K. Fuller
	Speaker: Hon. Kennedy Jones
2.30 p.m.	First Meeting of New Executive.

Host Branch Society	Western Counties Medical Society
President and General Chairman..	Dr. D. F. Macdonald
Programme and Entertainment	Dr. James Balmanno
Registration	Dr. G. M. MacDonald
Programme for Ladies	Mrs. D. F. Macdonald
Housing and Accommodation.	Dr. R. B. Auld
Publicity	Dr. G. D. Belliveau
Golf Tournament	Dr. M. J. Cassells
Exhibitors	Dr. W. F. Mason
Executive Secretary	Dr. C. J. W. Beckwith

The 6th Regular Meeting and the Annual Meeting of the Executive Committee will precede the general meeting.

Social Registration Fee - $10.00

CLIQUE (KLEK) n. (FR. = party, set) an exclusive set

Word has been going around that our Society is being run by a clique. On investigating this report I find it to be quite true. Furthermore, I find this clique is composed of faithful members who are present at *all* meetings, who accept appointments to committees, who give willingly of their time, efforts, and who honestly believe that the more one puts into the Society the more he or she gets out of it.

It is suggested that you join this clique! Your presence will be welcomed. J.F.F.

Maritime Medical Care Inc.

The Annual Meeting of the Board of Directors, Maritime Medical Care, Inc., took place on April 17, 1963. Immediately following this the first meeting of the new Board of Directors was held.

BOARD OF DIRECTORS M.M.C. INC., 1963-1964

Director	Physician Members, Branch Medical Society Represented	Appointment Expiring
Dr. C. H. YOUNG	Halifax Medical	1965
DR. H. B. WHITMAN	Pictou Medical	1965
DR. R. F. ROSS	Colchester-East Hants Medical	1965
Dr. E. P. Nonamaker	Halifax Medical	1964
Dr. T. B. Murphy	Antigonish-Guysboro Medical	1964
DR. C. A. D'INTINO	Cape Breton Medical	1964
DR. G. W. SODERO	Cape Breton Medical	1965
DR. D. F. MACDONALD	Western Counties Medical	1964
DR. F. W. PRINCE	Lunenburg-Queens Medical	1964
DR. G. E. KENNY	Valley Medical	1965
DR. D. C. BROWN	Cumberland Medical	1965
DR. A. W. TITUS	Halifax Medical	1964

LAY MEMBERS

MR. J. A. WALKER, Q.C.	— Halifax	1965
MR. J. NOBLE FOSTER	— Halifax	1965
MR. VICTOR N. THORPE, Q.C.	— Kentville	1965
MR. DAVID ZIVE	— Halifax	1964
MR. FRANK ROWE, Q.C.	— Halifax	1964

The Board of Directors Elected:

DR. C. H. YOUNG—Halifax—President

DR. T. B. MURPHY—Antigonish—Vice-President

The Executive elected are the Officers and —

DR. D. F. MACDONALD	—	Yarmouth
DR. D. C. BROWN	—	Amherst
MR. FRANK ROWE, Q.C.	—	Halifax
MR. J. N. FOSTER	—	Halifax

President's Report

ANNUAL REPORT

MARITIME MEDICAL CARE INCORPORATED

APRIL 17, 1963

Gentlemen:—

The reports to this 14th Annual Meeting of Maritime Medical Care Incorporated will bring to you a sense of satisfaction in their evidence of continuing growth and financial soundness of the Corporation's affairs.

In 1962, income from subscriptions increased by $267,159 to a new high of $3,811,232. Investment income rose to $72,583 on investments of $1,322.055. The appropriation for Stabilization of Payments to Physicians was $80,840, of which $9,440 represented 2% of Seniors' Health Plan subscriptions since the inception of that plan. The total of this reserve for Stabilization of Payments to Physicians now amounts to $242,830. An amount of $194,648 representing the surplus on the year's operations was appropriated for the General Reserve, bringing it up to $553,068 at December 31, 1962.

Percentage administration costs increased from 9.64% in 1961 to 9.80% in 1962, due mainly to increased expenditures on the acquisition of new quarters.

The General Reserve was set up on the actuarially sound principle that there should be available an amount equal to three months operating charges. In the relatively few years that monies have been set aside for this purpose it has reached a sum that is approximately equal to two months income at the current rate of usage. Necessary and admirable as this action has been, it has in a sense conflicted with your long term goal of reducing proration from 85% to 90%. Therefore it is recommended that you give further study to this subject.

The enrolment figures are as follows —

		Contracts	Persons
(1)	Comprehensive	43,995	128,583
(2)	Health Security	547	1,788
(3)	Individual Contract	1,746	4,748
(4)	Seniors' Health	9,039	12,353
		55,327	147,472

On August 22, 1962, you formally approved the Extended Health Benefit Contract, and on September 19, 1962, the Supplementary Hospital Benefit Contract.

The restrictions of denial of access to bases, depots and ships for new enrolment purpose, denial of pay assignment privileges for M.M.C. premiums for new members, and lack of government participation in premium cost, which were placed upon all underwriters other than the Government-sponsored Group Surgical-Medical Insurance Plan, forced you to cancel Armed Forces coverage effective December 31, 1962. The privilege of enrolment of service personnel as a family unit in one of M.M.C.'s Individual Plans was ratified.

As reported to you last year, Management worked closely with the Special Research Committee of The Medical Society of Nova Scotia in the preparation

of its Brief to the Royal Commission on Health Services. It is hoped that this close liaison and technical assistance will be maintained in the Committee's task of presenting to the Society a plan of prepaid physicians' services insurance to cover all citizens of the province of Nova Scotia.

It is the expressed conviction of The Medical Society of Nova Scotia and yourselves that the coverage of more Nova Scotian citizens by comprehensive physicians' services insurance is a desired aim, whether by M.M.C. or other non-profit carriers. However, this does not equate the carriers, nor affirm the replacement of M.M.C. coverage where it now exists as a matter of indifference to the members of The Medical Society. You have therefore by resolution to the Executive of The N. S. Medical Society asked that their members at their Annual Meeting affirm once more their unequivocal endorsement of M.M.C. as the only Society-sponsored plan in Nova Scotia.

The machinery for keeping each physician informed on Corporation matters is in the hands of each Branch Representative on the Board of Directors. In November of 1962 the General Manager commenced the preparation of summary reports for each of you as a guide to your presentations to Branch Society meetings. Conversely each Branch Society can express its views to the Board through its Branch Representative.

As a further step in closer co-operation you have approved the setting up of a Physician Relations Conference, and surveys of medical and subscriber opinions regarding desirable benefit changes.

The lay members of the Board continue to set an example of stability and of unshakeable faith in the rightness of policy and future of the Corporation.

You have expressed concern at the practice of plan payments to groups or associations rather than to individual physicians. Further requests that you have received for an extension of this practice underline the necessity of referring the matter to the Society membership for their resolution. However laudable the ends, the means are a clear violation of the fee for service principle.

The replacement of the check-off system in the New Waterford and Sydney Mines area by M.M.C. coverage was brought about by the support of the doctors in these areas, the skilled negotiation of management, and the comprehensiveness of our plans. However, the fact that the Queens-Lunenburg sales campaign had to be delayed until this effort was completed, points up the wisdom of an expansion of our Sales Department. You have approved this in principle. It is time to activate it.

You close the year with the knowledge that your deliberations have been fruitful, and that Management's execution of your policies has been faithful.

Respectfully submitted,

A. A. GIFFIN, M.D., C.M.,
President.

Auditor's Report

We have examined the balance sheet of Maritime Medical Care Incorporated as of December 31, 1962, and the statement of income and expenditure and general reserve for the year ended on that date and have obtained all the information and explanations we have required. Our examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as we considered necessary in the circumstances.

In our opinion, and according to the best of our information and the explanations given to us and as shown by the books of the Corporation, the accompanying balance sheet and statement of income and expenditure and general reserve, together with the notes thereto, are properly drawn up so as to exhibit a true and correct view of the state of the affairs of the Corporation at December 31, 1962, and the results of its operations for the year ended on that date, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Peat, Marwick, Mitchell & Co

Chartered Accountants.

Halifax, N.S
March 12, 1963.

Notes to Financial Statements

December 31, 1962

1. Effective January 1, 1961 the Corporation entered into a two year contract, in conjunction with similar medical service plans in Canada, to provide medical coverage for the employees of Canada's railways. The contract provides that at its termination the experience of the participating plans will be reviewed in order to determine the net gain or loss from the contract. The experience of each plan is then related to the experience of the group as a whole, and then appropriate financial adjustments made among the plans. Based on the 1961-62 experience of the Corporation on this contract, it is estimated that at December 31, 1962 the Corporation is entitled to a refund from the participating plans of approximately $73,000.

2. Under the terms of the agreement between the Corporation and the participating physicians, the Corporation may, after the expiration of a twelve month period, cancel any unpaid balances outstanding on approved claims. The Board of Directors has passed the necessary resolution to cancel all such unpaid amounts to December 31, 1961. The unpaid balances of approved claims for 1962, amounting to approximately $541,200 have not been reflected in the financial statements.

Maritime Medical Care Incorporated

Balance Sheet

December 31, 1962

(with comparative figures for 1961)

ASSETS

	1962	1961
Cash on hand and on deposit	$ 151,224	$ 122,698
Accounts receivable	24,301	26,038
Receivable from railway contract, estimated (note 1)	73,000	22,000
Prepaid insurance	287	404
Accrued interest on investments	18,443	14,154
Investments, at cost - quoted market value December 31, 1962 $1,324,589 December 31, 1961 1,096,628	1,322,055	1,083,695
Inventory of supplies, at cost	8,214	7,617
Furniture and office equipment, at cost	54,006	48,797
Less accumulated depreciation	23,205	21,819
Net furniture and office equipment	30,801	26,978
	$1,628,325	$1,303,584

LIABILITIES

	1962	1961
Medical claims payable	$ 547,810	$ 522,271
Unpresented medical claims, estimated	184,120	163,315
Accounts payable	10,639	6,144
Trust funds—Province of Nova Scotia Welfare Plan	24,914	32,923
Subscriptions received in advance	64,944	58,521
Total liabilities	832,427	783,174
Retained by the Corporation:		
For stabilization of payments to physicians	242,830	161,990
General reserve, per statement attached	553,068	358,420
Total retained	795,898	520,410
	$1,628,325	$1,303,584

MARITIME MEDICAL CARE INCORPORATED

Statement of Income and Expenditure and General Reserve

Year ended December 31, 1962

(with comparative figures for 1961)

	1962	1961
Subscription income	$3,811,232	$3,544,073
Expenditure:		
Medical care for subscribers	3,229,057	3,099,723
Administration costs, schedule "I"	373,603	341,630
Total expenditure	3,602,660	3,441,353
Operating income	208,572	102,720
Other income:		
Income from investments	72,583	53,752
Sundry	384	—
Total other income	72,967	53,752
Net income for the year	281,539	156,472
Additional payment from 1959-1960 railway contract	—	58,512
	281,539	214,984
Deduct:		
Appropriation for stabilization of payments to physicians	80,840	67,257
Write down in net value of furniture and fixtures to reflect depreciated value at December 31, 1962	6,051	—
	86,891	67,257
Balance appropriated to general reserve	194,648	147,727
General reserve at beginning of year	358,420	210,693
General reserve at end of year	$ 553,068	$ 358,420

The Scope of Child Psychiatry

C. A. Boddie, M.B., B.Ch.

St. John's, Newfoundland

The history of Child Psychiatry is relatively short. The term Child Guidance originated as recently as 1926. Prior to that time, those psychiatrists who were concerned with children usually restricted their activities to the care and training of mentally retarded in institutions.

Of course, other professions and disciplines have long been concerned with the study, care, and education of children. Scientists like Charles Darwin, Froebel, and Adolf Kussmaul, through the use of diaries, questionnaires and sporadic experiments had assembled a great deal of information about child development before Alfred Binet in 1905 began to study the means for adequate schooling of the retarded and worked out a "measuring scale for intelligence". Work in the field of child development saw such men as Gesell, and continues actively today in many centres for the longitudinal study of the child, such as that of Sontag at the Fels Institute and Senn at the New Haven Child Development Centre.

Theories related to the emotional life of the child have been strongly influenced by the observations of psychoanalysts who suggest that symptoms appearing in the adult are rooted in earlier childhood experiences.

Social scientists in their explorations of a variety of cultures added to our knowledge by creating an awareness of the influence of child rearing customs on the subsequent development of the child.

The major impetus for the establishment of Child Guidance Clinics came in the 1920's from the Mental Hygiene Movement with its concern for the recognition and care of socially disturbed and delinquent children. With the establishment of the so-called Demonstration Child Guidance Clinics, special psychiatric services for children had begun, but already the focus had shifted from delinquency and the courts to the broader aspects of the child's total functioning in the home, school and neighbourhood. Because of this early attempt to view the child as part of a larger scheme of things, the services of other disciplines were utilized. This trend continues today so that a Child Guidance Clinic is staffed by a child psychiatrist, a psychiatric social worker and a child psychologist. Each of these disciplines, through the use of its own investigative methods contributes to an understanding of the child, his particular symptoms, the family and its internal arrangements, and the relationship between the child, his family, and the community at large. In order to achieve such a comprehensive view of the child's total situation, it is necessary, not only to interview the child, but both parents as well, and also to have information from other significant persons in the child's life. It is also important to acquire accurate information, not only about the present, but about the past. More and more there is a tendency to regard emotional disturbance in the child, not only as an entity in itself, but as an indicator of disturbed family functioning. It has been said that there is no such thing

*Presented at the Atlantic Regional Meeting, Royal College of Physicians and Surgeons of Canada. Oct. 10th, 1962, St. John's, Newfoundland.

as a baby, only a baby and a mother. There is seldom an emotionally disturbed child in the absence of disturbed family functioning.

For example;

> John, an attractive, intelligent five year old, youngest child was urgently referred to the Child Guidance Clinic because of an overwhelming fear of school, which he had just begun to attend. This was associated with a marked sleep disturbance, a reversion to bed-wetting and nightmares, and gastro-intestinal upsets. He was a physically healthy child. An early indicator of John's disturbance became apparent in the waiting room when he was asked to separate from his mother. Both the mother and the child became extremely anxious and the mother required considerable re-assurance before she would accompany the social worker to her office.
>
> After a few interviews with the child, the mother, the father, and a report from the school, it became apparent that the father, an able intelligent, but remarkably distant man was frequently absent from the home, but even when present tended to remain aloof from his wife and children. The mother, an only daughter of indulgent but intrusive parents had married primarily to escape her parents' influence, but found herself increasingly unable to cope with the total responsibility for the children, and resented this. Partly because of her guilt on this account and partly because of an attempt to provide for her child as she had been provided for, she had become almost inseparable from her youngest boy, who also provided her with the emotional warmth she failed to get from her husband. The crisis came when the child had to leave home to go to school. Mother and child were about to separate.

This case illustrates some of the factors which may result in the appearance of emotional disturbance in the child exposed to disturbed family functioning and is a good example of the kind of case which can best be approached by the multi-disciplinary child psychiatric team.

The approach to treatment in a case such as this would usually involve the psychiatrist and the social worker. The first thing to be done is to help the mother get the child to school regardless of her own anxiety. Treatment proper would then commence, the psychiatrist working with the child with a view to helping him become aware of his separation problems, facing his anxiety and devising healthier patterns of dealing with it; the social worker seeing both parents in an attempt to deal with the factors in their behaviour which were contributing to the situation.

It is important to stress that fears such as those seen in this child are considerably more intense and disturbing than the normal anxiety many children experience on starting school, and that if such symptoms are not treated they tend to generalize and the long-term consequences for personality development are serious.

This case demonstrates other factors to be considered in the careful and selective utilization of specialized services: –

Phobic symptoms related to separation such as those seen in this case are often successfully dealt with by psychotherapy given to the family by the family doctor even if he does not call it psychotherapy. However, the same symptoms appearing for the first time in the middle years of childhood usually indicate a much more severe type of disturbance in the child which will not be relieved simply by helping the mother and child to separate. Treatment is more

difficult and prolonged. The appearance of these symptoms for the first time in adolescence may again be interpretated differently. Often it heralds the onset of a psychotic disorder and psychiatric referral is urgent.

In general, therefore, the younger the child the more likely the problem is to be related to disturbance in the mother-child unit.

Secondly, it is apparent in this and other similar cases that disturbed family functioning can manifest itself in the child's relationship to the community at large. However, disturbed relationships of a child with school and neighbourhood need not stem primarily from the emotional climate in the home. For example:

> Bill, a husky rather dull eleven year old child living in a condemned apartment without adequate heat and light appeared in Juvenile Court charged with stealing, truancy, and breach of curfew regulations. When the case was investigated it was found that Bill, an illegitimate child, was living with his grandparents, both infirm and though both were fond of him they were unable to provide sufficient incentive or discipline to attract him away from a gang of boys in his neighbourhood, all coming from similarly socially deprived homes. Bill's behaviour conformed in most respects to the norm for his group and he was neither more or less a problem than his peers.
>
> Assessment at the Child Guidance Clinic was carried out at the request of the Court, but the family was not accepted for treatment. Placement of the boy in a supervised training school for an indefinite period was recommended.

This case was not considered suitable for treatment on a family basis because a Child Guidance Clinic is an out-patient facility and weekly treatment sessions could not possibly have counteracted the overwhelming social problems met by this child. Secondly, even if the grandparents had been highly motivated, they were physically incapable of providing supervision for the boy. A Clinic can act *with* but not *for* parents.

This principle applies in all cases. There are, however, cases where such action is not the exclusive role of a child psychiatric service. For example, temper tantrums in a two year old child are usually readily dealt with by most parents – they are within the range of normal. If the parent cannot cope, parent counselling may help, but this is a minor problem usually and does not require the services of a psychiatrist. If, however, behaviour persists to an age when it is inappropriate, if it is repetitive and not related to surrounding circumstances and is adversely affecting healthy development of a child this is a different problem and one that may require more specialized help.

The contrast provided by these examples has been deliberately created to highlight the main point. This point is, that if an isolated specialized diagnostic and treatment facility is to provide a maximally effective service to the community in which it exists, it must be used selectively by its referring sources.

Indiscriminate use of a facility as a last resort for major social problems, or for the resolution of minor family problems, or as a place in which to have a diagnosis corroborated in a case which cannot be treated in that facility or in any other, will create insoluble problems for the patients referred, for the referral sources and for the facility itself.

Selective use of a facility requires knowledge of its function and ability to recognize cases suitable to its specialized role.

Elimination of referral of unsuitable cases can be achieved by treatment by the doctor or agency concerned in co-operation with the clinic if desired, or by referral to another suitable agency if it exists. If it does not, this is another problem.

Knowledge of the function of a facility is readily available by enquiry. Ability to recognize suitable cases is the joint responsibility of the facility and the referring source. It involves basically the laborious process of teaching and learning.

Certain general, principles, however, are fairly straightforward and some have already been suggested. In general, persistent, irrational, disturbed or disturbing behaviour of major degree and not reactive to the normal crises of life, and which interferes with the healthy emotional, intellectual and social growth of the child and his family, usually warrants psychiatric referral.

In making such a referral certain points should be borne in mind: –

(a) If the major contributing component of this disturbed behaviour is within the child and his family, psychiatric treatment is most likely to help if the family and child have some evidence of healthy functioning in the past or present and if the family is or can be motivated to accept the possibility of change.

(b) If the major contributing component of the disturbed behaviour is within the environment, two conditions must pertain if psychiatric treatment is to help. First, the environment must be amenable to change through the efforts of the treatment team, and the parents must be motivated to initiate, perpetuate and support such change.

(c) If the major contributing component is within the child as it might be in the case of organic brain disease, the family, again with assistance must be able to create and maintain conditions favourable to the continued existence of the child in the home and community. Drugs may help the child but are seldom effective when used alone.

(d) By contrast, if the child is reflecting severe psychopathology in a parent or parents, the parental disturbance should be remedied first and at an adult clinic.

(e) Similarly if the child's disturbance is a reflection of socio-economic deprivation or a prevailing delinquent norm, referral in the first instance should be made to a social agency equipped to deal with such problems.

It is not proposed to enter into a detailed discussion of the various types of emotional disturbance observed in children. In the most general terms, emotionally disturbed behaviour is appropriate to the stage of development of the child. In younger children of pre-school age it appears primarily in the relationship with the parents; in the middle years it may be manifested in difficulties in peer group and educational performance. Also, at this stage, due to the child's wider range of contacts, the first obvious signs of anti-social behaviour may become apparent, though it is very unusual not to have had prodromal symptoms for many years before which have been overlooked. At puberty and adolescence there are again disturbances appropriate to the problems being encountered by a child of this age. It is important to stress that great care is required in the assessment of adolescents, as it is at this age that psychosis, rare in children, now becomes a greater possibility, and yet it must be constantly borne in mind that adolescent adjustment reactions are

prone to resemble some aspects of psychotic behaviour – day dreaming, rapid mood swings, vague thinking among others being common to both.

As a final point, children are not small adults; they have emotional problems unique to their stage of development. If emotional disturbance is present, the whole family is involved. In common with the whole field of medicine, the earlier treatment is started, provided that the child and his family have assets and the greatest of these is desire for change, the better the result which may be expected.

Management of Non-Toxic Goitre
The Role of Needle Biopsy*

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Since 1956 we have treated selected patients with non-toxic goitre by the administration of either 2-3 grains of thyroid extract or 0.2 mgms thyroxin daily. As follow-up studies on the entire series have not yet been completed, this report concerns 50 patients, selected at random, on whom thyroid needle biopsies were performed, using the Franklin modification of the Vim Silverman needle. There were no complications. Patients ranged in age from 18 years to 75 years. There were 6 males and 44 females.

While aware of the limitations of needle biopsies, the use of this diagnostic method was initiated with three aims in mind: (1) To see how many patients (and particularly those responding to treatment) proved to have Hashimoto's thyroiditis which would have been unrecognisable by the usual methods of diagnosis. All patients with obvious Hashimoto's thyroiditis or subacute

*Condensed version of paper presented at the Atlantic Regional Meeting, Royal College of Physicians and Surgeons of Canada, Oct. 8th, 1962, St. John's, Newfoundland.

thyroiditis. patients were excluded from this series. (2) To determine whether or not any malignant lesion might be encountered – although all patients with strongly suggestive evidence of a malignant lesion were excluded from the series and were referred directly for surgical treatment. (3) To seek any other clues which might indicate why these goitres did or did not respond to medical treat ment.

RESULTS: The accompanying table shows the histologic diagnoses made on the basis of the needle biopsies. No malignant lesions were encountered. One of the most interesting findings was that 5 patients (10%) had chronic (Hashimoto's) thyroiditis which had not been suspected. Two others were difficult to categorize and have been included with the 33 designated as adenomatous goitre. The changes encountered in this latter group included various degrees of fibrosis, hemorrhage, cyst formation and even calcification. Such changes, when extensive, would seem to make response to medical treatment unlikely. Four patients had a microfollicular adenoma and these did not decrease in size during treatment – as compared with the patients showing chronic thyroiditis, all of whom responded well to treatment. One patient with a "cold" nodule demonstrated by scintiscanning was shown to have a cystic Hurthle cell adenoma which contained approximately 2 c.c's of fluid. Because she was 74 years old this patient was not treated.

A further report on the results obtained in the larger series of patients is being prepared.

TABLE I

HISTOLOGIC DIAGNOSIS – 50 NEEDLE BIOPSIES OF THYROID

Unsatisfactory Biopsy	3
Malignancy	0
Normal Thyroid Tissue	2
Lymphocytic Thyroiditis	5
Diffuse Goitre	2
Hurthle Cell Adenoma	1
Microfollicular Adenoma	4
Adenomatous Goitre	33

The Early Symptomatology and Diagnosis of Lung Cancer*

Frederick G. Kergin, M.A., M.D., M.S., F.R.C.S. Eng. and (C), F.A.C.S.*

Lung cancer has become much the most important cause of death from cancer in male patients. I do not have the figures for the Province of Newfoundland available to me, but in 1959 in Ontario, one man out of five who died of cancer, died of lung cancer. In that year, in that one Province, 826 men and 118 women died of lung cancer. In men there were twice as many deaths from lung cancer as from cancer of the prostate and half as many again as from cancer of the stomach. Facts like these have been well publicized, both in the lay and the medical press. But in spite of that, because cancer of the lung may be so subtle in its onset and mimic so many other common diseases, the early manifestations are frequently overlooked.

It is my purpose to report the result of a study which I have made of the time factor in making a diagnosis of lung cancer, to indicate the varied symptoms which may first appear to signal the onset of lung cancer and outline the diagnostic measures which should be undertaken when this disease is suspected.

In order to get some information about what the average delay is in making a diagnosis of lung cancer after the first significant symptom appears, I have made a study of one hundred consecutive patients who have been referred to me and who later were proved to have lung cancer. In ninety-one patients the delay could be assessed reasonably accurately and averaged five months. Analysing this further, it was apparent that the average delay between the first significant symptom and seeking medical advice was two months and the delay after seeing a doctor averaged three months. In the remaining nine patients only the total delay could be assessed and this averaged eight-and-one-half months. These figures should not be taken too seriously, as there was tremendous variation within this series of one hundred patients. In twenty-five there was no appreciable delay by the patient or by the doctor and investigation was carried out very promptly after the first significant symptom had been noticed by the patient. Among the others, however, one patient delayed as long as two years before seeking advice and in another patient there was a delay of one-and-a-half years after the patient consulted a doctor before this diagnosis was suspected. In looking back over these records it is apparent that the usual cause for the delay was that neither the patient nor his doctor thought for a moment about the possibility of lung cancer in the early phases of the illness. The symptoms were mistaken for some common affliction such as chronic bronchitis, influenza, spondylitis, or virus pneumonia, which incidentally I think occurs in fact much less often than the diagnosis is made.

The early symptoms of bronchogenic carcinoma are quite understandable if one thinks for a moment about the pathology of this disease. There

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*Presented at Atlantic regional meeting of The Royal College of Physicians and Surgeons of Canada, St. John's, Nfld., October 9, 1962. Dr. Kergin was Royal College of Physicians and Surgeons lecturer in Surgery at that meeting.

are two common types of this lesion. In about two-thirds of the patients the tumour begins in one of the larger bronchi and in one-third of the patients the tumour begins in the lung parenchyma as the so-called peripheral lesion.

In the first type the tumour begins in the wall of a larger bronchus and as it grows begins to occlude the lumen. This results in a chronic dry cough and very often a wheeze is noticed. As bronchial obstruction becomes more complete, there may be retention of secretions and infection, with a resulting segmental or lobar bacterial pneumonia. At about this stage the lesion is likely to ulcerate from a combination of insufficient blood supply and local infection, and the patient may then raise a small amount of blood or pink stained mucus. With infiltration of the bronchial wall by tumour there is involvement of the sympathetic and para-sympathetic nerves and this frequently leads to a deep-seated discomfort in the chest, which may progress to a distressing pain. Unlike pleural, cardiac or spinal pain it is unaffected by breathing or coughing or by exertion or spinal movement.

The natural history of the peripheral lesion is quite different. Growing as it does in the so-called "silent" area of the lung it may become quite large unless it is picked up by a chance radiographic examination as a coin lesion. As it grows larger one of several complications may occur. It may involve the visceral pleura to give pleural implants and lead to an effusion of blood-stained fluid into the pleural space. It may invade across the pleural space into the chest wall to cause local pain and tenderness. If it happens to be situated at the apex of the lung it may invade the brachial plexus to cause pain and paralysis in the arm and hand.

In the case of either type of lesion, before the lung symptoms become prominent, there may be symptoms from a remote secondary lesion. This may be a lump in the neck due to secondary carcinoma of a lymph node, cerebral symptoms, bone pain or enlargement of the liver.

In the series under study 68 patients had a tumour arising in a major bronchus and 32 had the peripheral type of lesion.

Translating all this into practical terms, what were the symptoms with which these one hundred patients presented themselves?

In 37 patients, more than $\frac{1}{3}$, the first significant symptom was a lung infection. This very often came on like an attack of influenza with cough and fever and signs of a localized pneumonitis. As a rule the response to antibiotic therapy was less dramatic and gratifying than it is in ordinary bacterial pneumonia. Some of the patients had several attacks of lung infection over a period of a few months. When any adult, and particularly a middle-aged man, develops pneumonia or any severe respiratory infection one should think of the possibility of partial bronchial obstruction by a tumour. It is not good enough to dismiss these infections as virus pneumonia. It is wise to have a film made of the chest during the illness and when a patient recovers to have a further film made to see whether the condition has cleared completely. If the patient has a bronchogenic carcinoma as the cause of his respiratory infection, the film will almost invariably show a residual shadow in the form of segmental atalectasis or infiltration and this means that further investigation should be undertaken.

Throughout Ontario there is a very active programme of chest radiography by miniature films carried on by the National Tuberculosis Association. 18 of the patients were referred because a routine radiograph of the chest had shown an abnormal shadow, usually a so-called "coin" lesion.

16 of the patients went to their doctor because of severe cough, usually of a dry or hacking type and commonly accompanied by a wheeze.

15 patients complained first of deep-seated, chronic chest pain.

10 patients first became alarmed by spitting blood and promptly sought medical advice.

In 4 patients the first significant symptom was due to a secondary lesion in the brain, a bone or an enlarged lymph node in the neck.

By the time these patients were seen, many of them had gone on to develop further symptoms. The above figures refer to the first significant symptom which might be expected to take the patient to his doctor.

It is noteworthy that the biggest single group comprises those who present with a respiratory infection and it was in this group that the longest delay occurred. The other long delay groups were those who had a chronic cough interpreted as "bronchitis" and those who had chest pain, which was commonly mistaken for spinal pain or cardiac pain. The patients who coughed blood or had a chance film showing an abnormal shadow were referred very promptly.

When a patient presents with any of these symptoms which suggest the possibility of cancer of the lung, what do we do? Our first obligation is to try to decide whether or not he actually has cancer, and if this investigation proves to be positive, to determine whether the cancer is still confined to his lung or has already extended outside the lung to render a curative resection impracticable.

In the patient with a "coin" lesion, we think of the other possibilities such as a tuberculoma, a histoplasmoma, or a benign lesion such as a hamartoma. Skin tests for tuberculosis or histoplasmosis are done and if one or the other or both are positive we at least give consideration to the possibility of the lesion being a benign infective granuloma. If precise X-rays of the planogram type show a well-developed nidus of calcification in the lesion, then we can assume that it is in fact a granuloma and simple observation is all that is required.

Whatever the appearance of the lesion in the routine P.A. and lateral films, we can usually obtain further information by extended radiographic studies. In this and the succeeding investigation we have in mind two considerations. The first is to decide whether the lesion is in fact a tumour and second, to determine whether, if it is a tumour, it is still confined to the lung and amenable to surgical extirpation. In the course of the radiographic investigation our colleagues, the radiologists, may find it advisable to use a fluoroscopic examination, spot films in various directions, planograms, and a barium swallow to determine whether the esophagus is deformed by secondary tumour in the mediastinum. A bronchogram is occasionally helpful but is not one of the more useful routine examinations.

In the meantime sputum is being obtained for cytological study. The success of this examination depends on two factors, first the interest of the physician in teaching the patient how to produce a good specimen for examination, and secondly the skill and enthusiasm of the pathologist in carrying out a meticulous examination of the specimen. It is the responsibility of the physician to instruct the patient that it is sputum from the lung which is wanted and not merely saliva from the mouth. The patient should obtain a specimen, first thing in the morning and before he uses his toothbrush, which simply causes exfoliation of cells from the gum to confuse the picture. Be-

fore breakfast, and before cleaning his teeth, he should rinse his mouth out with water and then do his best to bring up some sputum from his lung to put into a sputum bottle. Nurses, or physiotherapists, if properly trained, can be of great assistance in obtaining suitable specimens. Sputum studies are highly productive of positive results in the major bronchus type of tumours but are seldom helpful in the case of the peripheral tumours.

A carefully carried out bronchoscopic examination can give several different kinds of information which is helpful. The lesions arising in the major bronchi can be seen and a direct tissue biopsy obtained. The radiological localization of the tumours arising in the smaller bronchi or in the periphery allows the bronchoscopist to know in which lobe the lesion lies, and secretions may be aspirated from that particular lobe and these may show a positive cytological examination. In addition the bronchoscopist must examine the bifurcation of the trachea to see whether it is widened or fixed, to indicate involvement of the mediastinal nodes, or whether there is fixation or distortion of a major bronchus from the same cause. An incidental examination of great importance is to check on the movement of the vocal cords, as paralysis or impaired movement of the left vocal cord indicates involvement of the left recurrent laryngeal nerve by secondary tumour.

If, in the course of examination of a patient who is known to have a bronchogenic carcinoma, or suspected of having this lesion, one finds an enlarged node in a supraclavicular fossa, a biopsy of this node and the associated nodes in the area should be done. If positive for tumour, this not only confirms the diagnosis but also indicates that a surgical approach to the lesion should not be entertained. The term "scalene node biopsy" or "scalene node dissection" refers to excision of the scalene fat pad and section of the lymph nodes included in the fat pad in the absence of a detectable enlargement of the supraclavicular nodes. We have not found this a useful routine procedure in bronchogenic carcinoma. Our studies indicate that one must do fourteen scalene node dissections to find one positive result in patients subsequently proved to have lung cancer. On the other hand, we have an increasing interest in the recently introduced procedure of mediastinoscopy. This implies, under general anaesthesia, a small transverse incision above the manubrium with the creation of a tunnel along the treachea by blunt finger dissection and then the introduction of a small endoscope like a laryngoscope to visualize the lymph nodes about the bifurcation of the trachea. By using special forceps these nodes can be biopsied and yield a much higher percentage of positive results than the nodes included in a so-called "scalene node dissection". To date we have used this method thirteen times, have had no serious complications and are inclined to think that it will develop into a useful routine procedure in the assessment of these patients from the point of view of the advisability of surgical treatment.

Some of these patients, and this applies particularly to the peripheral lesions, have a shadow typical of a bronchogenic carcinoma, no evidence of secondary disease anywhere, and all the tests mentioned fail to yield a positive proof of the diagnosis. We do not favour direct needle biopsy, except when the tumour is known to be invading the chest wall and is obviously unsuitable for resection. In the typical "coin" lesion, not infrequently we have to resort to a thoracotomy not only to prove the diagnosis but also carry out the appropriate treatment at the same time. This may be a lobectomy or a pneumonectomy, and very frequently is the former.

Assuming that by one means or another one has reached the conclusion that a patient is suffering from lung cancer, then the next obligation is to decide whether or not he should be treated surgically. I have already metioned some of the observations, such as a paralysed vocal cord, a positive node in the neck, invasion of the chest wall, mediastinal involvement as demonstrated by vena cava obstruction, or evidence of cerebral or bone secondaries, which would immediately indicate that surgical treatment should not be carried out. As previously mentioned, a barium swallow may show a deviation of the esophagus to indicate gross mediastinal secondaries. There is a group of patients in whom the films, including planograms, suggest the possibility of nodes about the hilus of the lung extending into the mediastinum. In these patients we perform a pulmonary angiogram by introducing a small catheter up the cephalic vein into the superior vena cava and by injecting an opaque medium and taking a rapid series of films, obtain a very clear picture of the pulmonary artery in two projections. If it is obviously deformed or obstructed near its origin by external pressure of enlarged nodes, we then accept this as evidence that the patient should not be operated upon.

In summary then, I wish to emphasize that primary bronchogenic carcinoma is so common that one must think of this possibility in relation to almost any type of chest symptom, and in particular in the case of an adult man who develops a respiratory infection. If there is reason to suspect lung cancer and some radiological support for this suspicion, then there is a whole programme of investigation which is appropriate and which I have outlined briefly.

From the point of view of therapy, surgical excision of the appropriate lobe or lung is still the method which offers the best hope of cure. Of all the patients who prove suitable for a curative excisional operation, one in four will be alive and apparently free of disease in five years. Many of those patients who prove to be unsuitable for surgical treatment should receive the benefit of radiotherapy by the modern type of cobalt unit or betatron. This is curative in only a few exceptional cases, but in many patients does lengthen life and defer disabling symptoms.

FROM THE BULLETIN OF 40 YEARS AGO

The Medical Society of Nova Scotia Bulletin, May 1923

The Ontario Medical Society is arranging for clinical instruction in the use of "Insulin". From the correspondence that is printed and published in this issue the manner in which this can be carried out is clearly noted. If there are any physicians in the Province who desire to take advantage of this offer and would indicate what time it would be convenient to go to Toronto, arrangements can be made through the Associate-Secretary, or direct with Dr. T. C. Routley, 127 Oakwood Avenue, Toronto. In view of the great interest aroused by this latest discovery, it was felt that the information should be given to all members of the profession as quickly as possible.

BOOK REVIEW

THE GENERAL PRACTITIONER. By Dr. K. M. Clute. University of Toronto Press 1963, 546 pp. $12.00.

Whether or not one agrees with the findings and /or the conclusions of the author, one must agree that they are based upon the most comprehensive and exhaustive survey of the general practice of medicine ever carried out in Canada.

This survey was initiated in 1955 by the College of General Practice of Canada, to determine the factors affecting the quality of medical practice to enable the College to become better informed about the whole field of medical practice and thus be in a position to advise intelligently on the education of family physicians. A great deal of attention was thought to have been given to the specialist and his problems and standards. Little or none has in the past been given to those of the general practitioner.

The author was given, in his own words, "absolutely free rein throughout the whole work" nor was there "any interference on the part of any of the interested organizations."

It seems a pity that Dr. Clute took this "absolutely free rein" so literally that once his appointment was made, he shut himself away in his own little ivory tower, hoarding the results of his (and his associates') observations like a miser with his gold, seldom seeking advice from his Advisory Committee, even on statistics, which he admits is not his strong point. With the wealth of experience and talent in this Committee he might have shewn better judgment to have sought advice more often, and to have been less hesitant in taking the members into his confidence.

It must be emphasized that the findings of this survey, and the conclusions drawn, *are those of Dr. Clute and his associates* and are not those of the initiators or the sponsors. Nor are they those of the Advisory Committee set up to guide the survey.

The Advisory Committee never approved the preparation of the report for "the medical and the non-medical reader alike" as is stated on the front cover of the book. On the contrary, the College, the Advisory Committee, and the doctors being surveyed all understood from the start that it was meant as a scientific research project for the profession, and particularly for medical educationalists, and that it would be published in paperback, as all other such projects of the University of Toronto are published.

It is obvious that somewhere along the line there has been a change of policy on the part of the publishers (i.e. University of Toronto Press) which must at least have been acquiesced in by the author. This is further borne out by the fact that eleven days before the book became available, and ten days before the College received a copy, University Press sent copies to 36 people, including twelve newspapers from the Saskatoon Star-Phoenix to the Halifax Chronicle-Herald. These were accompanied by a press release which went out of its way to point out the percentage of poor and unsatisfactory practices unearthed by the survey. This apparent breach of faith by those responsible may well have far reaching effects. Where in the future will a group of doctors be found willing to take part in surveys of any kind, with memories of these revelations in mind?

It was not the intention of the survey, as initially visualised, to compare figures in the two Provinces and to do so, as the author has consistently done throughout, appears dangerous and unwarranted. For example, the survey in Nova Scotia was made between 1958 and 1960, and was obviously carried out more rigorously and in greater detail as a result of mistakes revealed in the Ontario survey of 1956 and 1957.

Dr. Clute proceeds to a very careful analysis of a well conducted survey, drawing detailed conclusions on almost all aspects of medical practice, from the amount of time a doctor has free from his practice duties, (and that is remarkably little in many cases) to deficiencies in his education, whether at medical school, internship or in his continuing educaion. The doctor is considered as a man, as part of the community, as a spouse and parent, as to his income, and in many other aspects. The lesson one chiefly draws is that if he may fall short in the standard of his practice (and it would appear that this is indeed the case with many) it is more than likely due to a combination of his being inadequately prepared, overworked, underpaid, and lacking in the time or opportunity to improve himself.

Positive recommendations are offered in almost all sections of this book, and while one recognizes that they may have as much of Dr. Clute in them as of the information gleaned in the survey, yet they deserve careful study by all concerned with the standards of medical practice. Both the College of General Practice, which commissioned the survey, and medical educators will have much to learn from these pages, and it may well be that "This imaginative project will be one of the most important factors in improving the quality of the services, and the conditions under which these services are rendered, by that least hallowed group of our profession, the G.P."

F.M.F.

Dr. James Angus Doull

An Appreciation

Dr. James A. Doull, Medical Director of the Leonard Wood Memorial for the Eradication of Leprosy, died in Baltimore, Md., after a two month's illness.

He was born at New Glasgow, N. S., on September 8, 1889. He was graduated B.A. in 1911, and M.D., C.M. from Dalhousie University in 1914. He served in the R.A.M.C. during World War I, attaining the rank of Major, and awarded the Military Cross and the Croix de Guerre. Immediately after the war he did graduate work in the field of Public Health and secured the degree of D.P.H. from Cambridge in 1919 and the Doctorate in Public Health from Johns Hopkins in 1921. While at the latter university he was a Rockefeller fellow in 1920, and an Associate in Epidemiology in 1921.

Returning to Nova Scotia he became Chief Health Officer of the Province, a post which existed before a regular Department of Health was created. It was due to his efforts that the Province really came to grips with its infectious and contagious diseases. It was under his guidance that case finding in tuberculosis was initiated with travelling clinicians from Halifax going throughout the Province. His stay here was all too short, and when a successor was found in the person of Dr. A. C. Jost he returned to Baltimore to pursue research in epidemiology particularly in respect to the common cold and diphtheria from 1924 to 1930. During this period he held the rank of Associate Professor.

In 1930 he was appointed Professor of Hygiene and Public Health at Western Reserve University School of Medicine, Cleveland, and held this post for fifteen years during which time he did surveys for the United States Public Health Service in various parts of the world. After the outbreak of World War II he was sent on a special mission to Australia and New Zealand to negotiate their procurement of Lend-Lease medical supplies and equipment from the United States. He also served on an International Committee convened in London to draft new sanitary conventions for maritime and aerial commerce regulations for medical control of displaced persons in Europe under UNRRA. He was also one of the original planners of the International Health Organization, and represented the United States at the conference in Paris in 1946 which resulted in the formation of the World Health Organization. He continued to serve as a consultant and member of its Leprosy Panel when it came into being.

In 1945 he was a member of the United States delegation to the conference in San Francisco which created the United Nations.

Dr. Doull left Western Reserve in 1946 to join the Regular Corps of the United States Public Health Service. Prior to this he had become deeply interested in the international problem of Leprosy and from this time up to his death all his activities centered in this field.

As Medical Director of the Leonard Wood Memorial for the Eradication of Leprosy he was at the forefront of all United States effort in this field and became a world wide authority. Under his guidance the first scientific method for determining the effectiveness of chemotherapy was evolved, and at the time of his death it would appear that more research in leprosy was being carried out by his group in many countries than by any similar organization in the world.

Besides those already mentioned Dr. Doull at one time or another received the following awards: Chevalier, Ordre de Sante Publique (France), Commander, Military and Sovereign Order of St. Lazarus of Jerusalem, Honorary Member Belgian Society of Tropical Medicine, Honorary Fellow of the Royal Sanitary Institute, London, Fellow of the Royal Society of Tropical Medicine and Hygiene, London, and Honorary Fellow of the Argentine Society of Leprology. Besides these he was a member of numerous societies connected with the field of Public Health and took a leading part in many of them.

His publications were numerous and varied and in epidemiology dealt with diphtheria, poliomyelitis, typhoid fever, and tuberculosis as well as leprosy.

Although in his seventy-fourth year he was actively engaged until a short time before his death. In correspondence with relatives last year he spoke of his age and possible retirement but his interest and zeal were in no sense diminished and he seemed amazed that the years had passed so quickly.

He is survived by his wife, Ethel Mary (MacQuarrie) Doull, a son, Dr. James A. Doull, Jr., of Cleveland, a daughter and six grandchildren. Also surviving are two brothers, Hon. John Doull, Halifax, and G. Roy Doull, Moncton, and a sister, Mrs. W. J. MacDonald, of Winnipeg.

On April 10th, 1963, he was buried in Arlington Cemetery.

Few graduates of Dalhousie's School of Medicine have achieved the international fame of Jimmie Doull, and in his own special field he was a world figure. Honors from many sources were showered upon him but they never changed his point of view. He was always the earnest seeker after truth, humanitarian to a degree, who saw the healing of the sick as his primary purpose in life. The acclaim of his fellows only increased his humility as an agent to that end. He died "in harness". We are proud of him!

The Bulletin extends its sincere sympathy to all members of his family in Canada and in the United States.

H.L.S.

THE HANDBOOK ON ARTHRITIS

When you make a diagnosis of Osteoarthritis of the knees, you may advise your patient to lose weight, you may prescribe exercises to strengthen his quadriceps muscles, and you may discuss with the patient the nature of the ailment. Sometimes there will be a shortage of time in which to answer the many questions in your patient's mind, and often he will leave the Office and further questions will occur to him.

To assist you with this problem the Canadian Arthritis and Rheumatism Society has prepared a 20-page booklet entitled "Osteoarthritis - A Handbook for Patients", which is intended to help the patient to co-operate more effectively with his Physician. It is not a guide to self-treatment. It answers such questions as: What is Osteoarthritis? What are its effects? Is it serious or crippling? What sort of diet should I follow? What forms of treatment are used? What is a Physiotherapist? It also advises on proper posture and the correct way to lift. There is a supplement of therapeutic exercises which can be given to the patient by the Physician. This handbook is not distributed to the general public, but is available to them through you. You can obtain copies of this handbook and similar handbooks dealing with Rheumatoid Arthritis and with Gout, from the Divisional Office of the Canadian Arthritis and Rheumatism Society at 353 Bayers Road, Halifax.

J. F. L. WOODBURY

Personal Interest Notes

Dr. N. B. Coward and Dr. J. C. Acker have returned from holding clinics under the auspices of the N. S. Society for Care of Crippled Children held at Truro, Springhill and New Glasgow. These are made possible by the Easter Shield campaign. A slight drop in attendance was noted. 130 patients were examined.

Cumberland Medical Society

Dr. and Mrs. Ralph Price of Amherst have returned home from a two week holiday in Jamaica. (Wonder if they missed the snow).

Halifax Medical Society

Dr. C. H. Young of Dartmouth was elected president of Maritime Medical Care at its annual meeting on April 17. He succeeds Dr. A. A. Giffin of Kentnille. Reports at the meeting indicated that this doctor sponsored plan had a record for growth for 1962, a net increase of 11,650 persons.

Dr. M. R. Harlow received his certificate from the Atlantic School of Journalism and Communications. The first class in Public Relations to graduate from the school recently completed a 16 week course under the direction of Mr. Bruce Cochrane.

Dr. F. D. G. Fullerton is the new President of the Halifax County Horticultural Society. Dr. A. B. Crosby is chairman of the Flower Show, Aug. 24.

Cape Breton Medical Society

Dr. and Mrs. G. W. Sodero, Sydney, were passengers to the United Kingdom on the Halifax Board of Trade chartered T.C.A. jet on April 22.

Births

To Dr. and Mrs. D. C. Langille (née Beverlee Chase), a daughter, Karie Lynn, at the Fishermen's Memorial Hospital, Lunenburg, on March 31, 1963.

To Dr. and Mrs. J. C. Crosbie (Martha Harlow), March 19, 1963, at Royal Maternity Hospital, Glasgow, Scotland, a daughter, Sheila Louise.

To Doctors L. Leslie and Edith Kovacs, on April 5, 1963, atthe Grace Maternity Hospital, Halifax, a son.

To Dr. and Mrs. Michael A. MacKinnon (nee Mary Gillis, R.N.), at the Halifax Infirmary, on March 30, 1963, a son, Gerard Alexander.

Congratulations

To Dr. Nicholas Destounis, of Halifax on his election as a Fellow of the U.S. Academy of Psychosomatic Medicine at its meeting in Chicago. The appointment came for Dr. Destounis' contribution to the field of Psychosomatic Medicine and its associated disciplines.

To Dr. D. C. Canteloupe, Lunenburg, for the award of a $500.00 scholarship (Upjohn Co. of Canada).

To Dr. H. C. Still, Halifax, for the award of a Schering Corporation bursary ($500.00)

The above awards are to help the doctors attend two week post-graduate courses at major medical centres in Canada or the United States. They were selected from among 500 applicants by the provincial education committees of the College of General Practice.

Obituaries

We regret to record the death of Dr. James Angus Doull on April 6, 1963, in Baltimore, Maryland. He was buried in Arlington National Cemetery after a military funeral conducted by United States Military chaplains. He graduated from Dalhousie and practised in Glace Bay before serving in France with the 193rd Field Ambulance, R.M.C., where he won the Military Cross and the Croix de Guerre. Following further studies at Cambridge, he, as Provincial Health Officer, led a province wide drive to control Tuberculosis. Later he studied and joined the staff of Johns Hopkins University. In the years since 1926 he had been active in Public Health projects in the United States and Brazil, the Philippines and the Orient, especially with the control of Leprosy. In World War Two, he became chief of International Health Relations division, of the U.S. Since 1948 he devoted his whole time to the Leonard Wood Foundation Public Health Service and was given the rank of Colonel. To his immediate family and his brother, Hon. John Doull we extend our sympathy.

On April 2, 1963, in Burlington, Vermont, the death occurred of Dr. Roderick Grant, a former physician of Wolfville, after a short illness. A Newfoundlander, Dr. Grant graduated from Dalhousie and took post-graduate work at the Universities of Michigan, Glasgow and London. After some time on the staff of the St. John Tuberculosis Hospital, he was travelling TB diagnostician for New Brunswick, and later practised for 15 years in Sussex, N.B. For the last sixteen years he has been on the staff of the Vermont State Hospital, Waterbury, Vermont. At the time of his death he was in charge of the Mental Rehabilitation program for the State of Vermont. He was buried in Wolfville on April 5. We extend our sympathy to his immediate family and to his sister, Mrs. F. H. Sexton.

April 26. Funeral service was held at Red Bank, N. B. for Dr. Frank Wilson a Sydney native, and Dalhousie graduate of 1923 who had practised in Red Bank for 38 years. After graduation he became associated with the late Dr. M. T. Sullivan in Glace Bay and later with the late Dr. D. J. Hartigan of New Waterford and then was in Newfoundland for a short time. Our sympathy is extended to his family.

Coming Meetings

American Geriatrics Society: June 6, 7 and 8, 1963.
Queen Elizabeth Hotel, Montreal.

Programme Headings

"Cooperative Efforts for Progress in Geriatrics".
"Geriatrics Management in D.V.A."
"Panel Discussion on Cardiovascular Disease in the Aged", and on
"Problems of Surgery".
"Problems of Anaesthesia in the Aged".

The Nova Scotia Division of The Canadian Anaesthetists Society

The Nova Scotia Division of the Canadian Anaesthetists Society continues to enjoy a successful and highly productive 1962-63 season.

The regular monthly meeting on 15 April, 1963 was held at the Canadian Forces Hospital, Halifax and attracted a good turnout of members. Dr. Bedwell discussed the value of EEG monitoring in Anaesthesia and Surgery in a most comprehensive and practical manner and was followed by Dr. Barsoni who gave an equally interesting and stimulating talk on "Reflex Activity Under Anaesthesia".

The talks were followed by election of Executive members for 1963-64. Drs. I. E. Purkis and A. C. Yelland were re-elected to the Chairman and Sec.-Treasurer positions respectively, the former for the third consecutive year and the latter for the second.

On 18, 19 and 20 April the combined meeting of the Atlantic Provinces Anaesthetic Societies was held in Moncton, N. B. The Nova Scotia Division was responsible this year for arranging the programme and considerable work and effort went into the Professional and Social preparations for the meeting.

Dr. Barrie Fairlie, Toronto, Dr. Code Smith, Toronto, and Dr. Alan Noble, Montreal were invited to Moncton as guest speakers and presented respectively papers on "Evaluation of Respirators for Intensive Care Units", "Some General Aspects of Paediatric Anaesthesia", and "Respiratory Problems in the Recovery Room". These papers proved most informative and topical and were greatly enjoyed by all present.

The remainder of the programme consisted of papers compiled by members of the Atlantic Divisions and all speakers are to be commended upon the excellent standard of their presentations.

In summary, it may be said that the meeting was a great success in every way and we all look forward to an equally stimulating gathering in 1964 with the N. S. Division again responsible for the preparation and organization of the programme.

CORRECTION: Please note that the CORRECT DATES for THE PHYSICIANS' ART SALON are **JUNE 10 to 14.**