THE NOVA SCOTIA MEDICAL BULLETIN

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Chronic Disease Control

The control of acute communicable diseases as the major causes of death and disability has been achieved in Nova Scotia largely within this century. Safe water and food supplies, immunization and finally antibiotics have changed the pattern of disease in our population dramatically. Thus the public has come to expect a specific treatment and a "cure". While much remains to be done in the control of hospital cross infections and in developing vaccines or drugs against the many agents now being identified as causing the "common cold", it is the long-term illnesses for which we have no specifics or "cures" that constitute the great burden of disease today. Already a majority of patients presenting in home, office and hospital are suffering from one or more of these "chronic" diseases. The greater our success in prolonging life, the more common these diseases will become, since they are more prevalent in the advanced years of life.

Clinical research and medical education have already accepted the need for greater emphasis on chronic illness. However, the organization of our medical services and institutions for care of the sick has been slower to change. McKeown in Birmingham writes of the need to develop a "balanced hospital community", in which the acute general hospital beds needed for care of the patient requiring short-term intensive care, will be "balanced" by an appropriate constellation of long-term care and custodial care institutions. Greater use of medical specialists and specialized diagnostic and treatment facilities seems indicated. In study after study, perhaps most scientifically in those by the Commission on Chronic Illness in Hunterdon County in the United States, it has been shown that our services are not geared to the needs of the patient with insidious, long-term illness. A majority of medically disabled patients from a large random sample of the population were found on clinical examination to be more seriously disabled than the examining team felt they should have been, primarily because the doctor who had seen them in the previous year had not made the diagnosis and provided the appropriate therapy. Even when the patient is examined for the more serious diseases for which he may not be presenting to the doctor's office, and necessary consultation is available and obtained, the providing of continuous, long-term supervision to the diabetic, the hypertensive, the hemiplegic or the terminal cancer patient is often impossible under present circumstances.

There is no question here of assessing blame. There **is** need to plan for the control of chronic diseases in an administrative or organizational framework that will help make the best clinical practice available to those with long-term illness in all parts of Nova Scotia. The articles in this issue of the *Bulletin* by **Dr. G. G. Simms** and **Dr. J. J. Stanton** describe major steps towards a balanced pattern of long-term care facilities of acceptable quality. Those by **Dr. A. A. Macdonald** and **Dr. P. C. Gordon**, suggest we still have a long way to go.

Coordinating Editor; Dr. G. H. Hatcher

The conceptual framework that has been so effective against infectious diseases may also serve for the community-wide control of chronic diseases, but as yet we do not know how much emphasis should be placed on the various elements of the program. They should include, presumably:

1. Control of the environment, such as air pollution control for the reduction of chronic respiratory diseases.

2. Early detection, in the asymptomatic, of precursors of disease, or of disease at a stage where it may be treated with some success, such as Papanicoloau screening for cancer, tenometry for glaucoma, or a battery of screening tests for selected high risk groups.

3. Specific clinical preventive measures in the management of illness, such as weight reduction, rheumatic fever prophylaxis, contact reporting and follow up for syphilis.

4. Continuity of care, to keep the patient under adequate medical supervision and appropriate nursing or other care. Periodic mass screening of the population can return some "lost" patients to care, and the institutional facilities described in this issue will help create a parallel series of services for non-hospital patients, similar to those that the physician can now call on for the acutely ill in general hospital.

5. Rehabilitation of the patient to maximum social function, if only to some level of caring for himself and finding life worth living. It is surprising how much mental and physical improvement result from relearning bowel and bladder control, or from limited ambulation. Rehabilitation is needed in the chronic care institution as much as in the acute general hospital and in the convalescent rehabilitation centre.

It is not clear how we are to secure the necessary co-ordination of services of the generalist physician and of various specialists, with the patient's family and with voluntary and public agencies and institutions in the community, to achieve continuity of care for the long term patient. This seems to be the point where the parallel with the general hospital for the acutely ill has much to offer. The organization of medical staff, nursing, social and rehabilitation services in a general hospital can serve to some extent as a model for chronic hospitals, nursing homes, and home care programs. Yet to some extent also our chronic illness problems exist because the general hospital succeeded in isolating itself from the total medical care needs of the community, and dealt only with a short term episode in the illness of each patient. Studies of repeated readmissions of cardiac patients to hospital with congestive failure illustrate both the advantages and the disadvantages of accepting only limited responsibility for long term illness.

Probably we will experiment with various ways of co-ordinating acute and long-term care in different communities in Nova Scotia as the new institutional care services develop, In the United States federal demonstration grants are available, to be matched by local communities, not for pure research alone, but to try out different ways of providing co-ordinated chronic care services that are suitable in a given locality. Even under universal medical care insurance, to ensure good and continuous long-term care what will best meet the needs of Africville may not be appropriate in Neil's Harbour. With imagination, and initiative we can make the care of the long-term patient outside the acute general hospital as exciting and professionally satisfying as the most glamorous surgery. At the same time, let us make the fee schedules for the two types of care more comparable.

G. H. H. □

Doctors Fee Services Provide Profits for Commercial Insurance

Commercial insurance is often of the indemnity type, and only part of the doctor's bill is paid. If you accept this as payment in full, and do not bill the patient for the remainder of your fee, the patient is receiving medical services at a discount. Who benefits? Not the patient, who has received the full service; not the doctor, who foregoes his full fee, but the insurance companies, which can only stay in business by offering fewer benefits than non-profit making companies.

Remember: - support Maritime Medical Care, and bill the patient whose insurance company does not pay your full fee.

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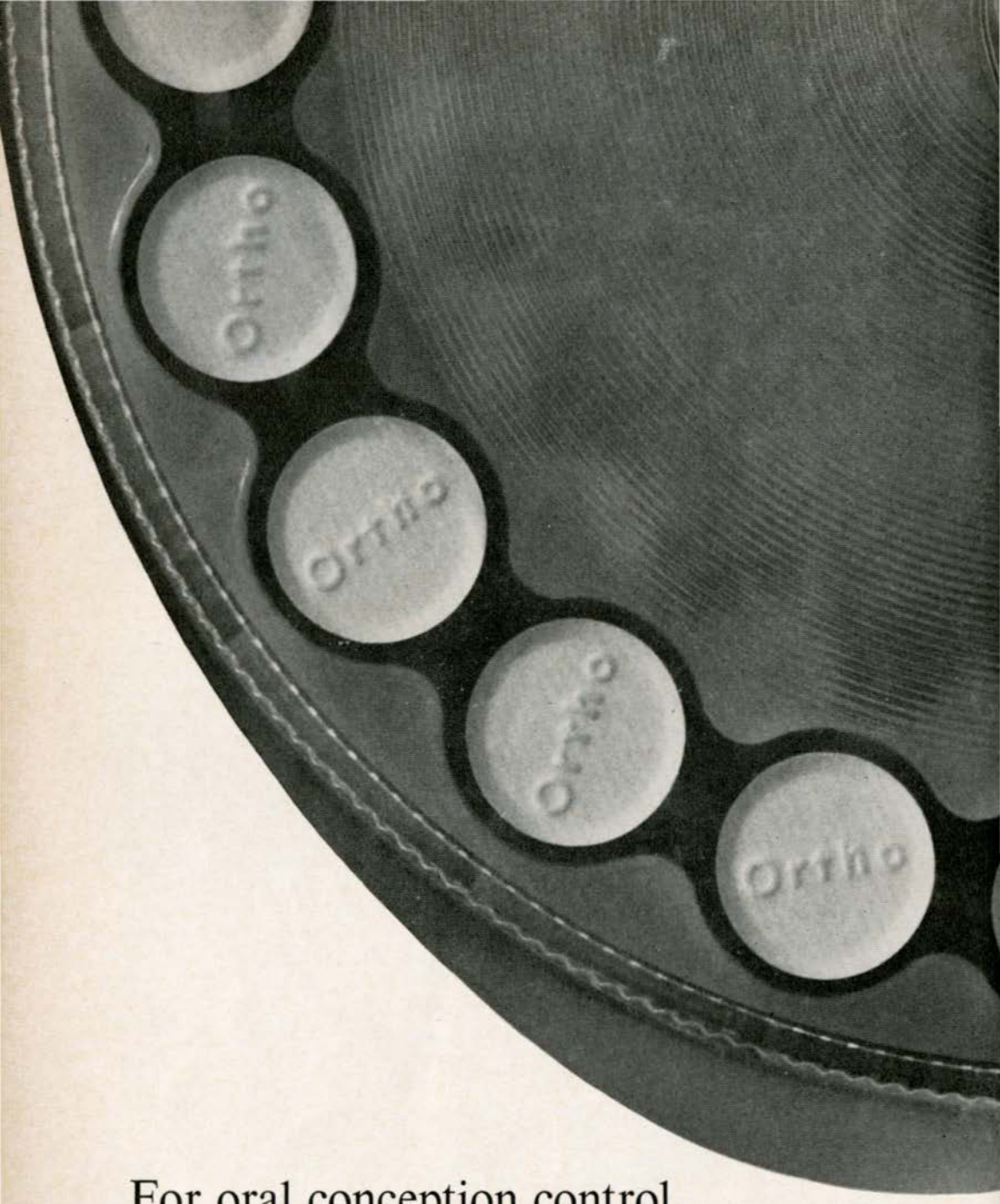

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Problems of Long Term Illness In General Hospitals

A. A. Macdonald, M.D.[1]

Sydney, N. S.

The problem of disposal of patients with long-term illness, or with particular professional or domiciliary care requirements, is a difficult one in most communities. It is an important factor in day to day availability of active treatment hospital beds. It is directly related to the presence or absence of suitable alternate facilities in the community. Every physician who serves on the Standards Sub-Committee of his local hospital, is aware of the pressures and difficulties related to this problem. Every physician who admits patients to active hospital beds, knows the difficulty encountered in discharging patients, when the time comes for less active medical and nursing care. Many patients have inadequate financial and home facilities, and must be cared for in some other facility during illness and convalescence.

In a previous paper by Dr. Peter C. Gordon (1) based on studies by Hatcher, Wanklin and Gordon[2], some of the deficiencies of our present chronic care facilities are demonstrated. The large numbers of people needing such care are also impressive. Studies by local Health Officers in other parts of Nova Scotia, reported by Dr. Stanton in this issue of the Bulletin, support some of these findings, although in less detail. Other data as yet unpublished, made available to the Nova Scotia Medical Society Committee on Ageing, relating to the levels of care needed by patients in our "acute general hospitals", are also based on research by Dalhousie's Department of Preventive Medicine under their grant to study factors influencing the quality and quantity of hospital care. They substantiate findings in other places, that many of our hospital patients could be cared for just as well in some more appropriate chronic care institution, or in their own homes.

Dr. Gordon's previous paper dealt with various categories of patients presently cared for in the facilities which he calls (a) Professional Nursing Homes, and (b) Professional-Domiciliary Homes. Dr. Gordon has dealt with the following factors: Sex Distribution, Age, Marital Status, Length of Stay, Mental Status, Bed Status, Ability to Walk, Medical Diagnoses, and Physical Impairments. He discussed the problems of providing various types of professional care at various levels of intensity, of the continually changing status of the patient with long term illness, and of the undesirable effects of frequent transfers of the patients from one facility to the other. He discussed avenues of approach to planning of comprehensive care facilities, and points out that certain urban communities in Canada have already developed comprehensive facilities, on a limited basis, providing different levels of care. In this issue Dr. Gordon's discussion of organized home care programs underlines the complete absence in Nova Scotia of another alternative to hospital care.

There is need now to approach this problem from a different aspect. Little is known, or at least, little factual information is available, about the extent of the need for special long care facilities at the community level. People who are mentally competent and financially independent can provide for their own care in communities where suitable facilities exist. Those who are financially or mentally dependent cannot do this. The facilities that exist in most communities, whether village, town or city, in Nova Scotia, fall in the class of (1) Municipal facilities catering mainly to patients with mental illness, or (2) are simply Domiciliary Units, with little or no Professional Nursing Care available. Consequently, the convalescent care or other long term care of independent as well as dependent patients becomes an unwanted function of the active treatment Hospital. Frequently it is impossible to discharge such patients till they are ready to care for themselves, or be cared for at home, if they do have homes.

The physician in practice sees and deals with these problems on an individual patient basis. He is frequently under pressure from his hospital staff or its Standards Committee, to discharge long stay or convalescent patients. The disposal of each such case is a problem of some magnitude, and often there is no satisfactory solution open

[1]Chairman Committee on Ageing, Nova Scotia Medical Society.

[2]Financed by Federal Public Health Research Grant 602-7-42.

to the physician. From his viewpoint, this is a grave problem, repeating itself at very frequent intervals. That there is a need for more patient care facilities than our general hospitals should provide is recognized by all. The nature and the extent of the facilities required in any particular Nova Scotia community is not really known at this time.

Studies must be instituted to determine the extent of the long term care problem at the community level. These studies must provide facts relative to socio-economic, medical, and institutional aspects of the problem. The information gained must be such that it may be applied to communities of equivalent size and composition throughout this province, or even throughout Canada generally. Specific plans regarding community facilities can only be started, when the necessary basic information becomes available. Studies that have been completed in other countries may be applicable, or partly applicable here, and may be helpful in later planning. Studies presently in progress elsewhere in Canada, should be applicable to similar communities, and may later be of help here. In Nova Scotia, studies in the Halifax area, and the review of patients in local mental hospitals and municipal welfare homes reported in other articles in this journal, are a good beginning. In Antigonish also, St. Martha's Hospital is exploring with other community agencies and St. Francis Xavier University, another approach to this problem.

The Canadian Medical Association Committee on Ageing, and the Committees on Ageing of the various Provincial Divisions, have taken, and are taking, an active interest in the problems of long term patient care. Occupancy studies of existing facilities indicate that a very high proportion of the patient population is in the age group 65 years or over. The Committee on Ageing of the Nova Scotia Division of C.M.A. is presently attempting to set up an active project to obtain just the type of information outlined above. This will be carried on a pilot basis first, and depending on the results of this, a more active programme may then be undertaken.

The present hospital insurance scheme in Nova Scotia functions well, and attempts to provide the necessary number of hospital beds for active medical care in each community. This aim tends to be frustrated by the present lack of Chronic Hospitals, Rehabilitation Centres, Professional Nursing Homes, and Professional Domiciliary Homes, for patients of all financial categories, and of Domiciliary Homes for wholly dependent patients. The present situation in most communities results in a real lack of active treatment beds at times, even in those communities which in theory have a sufficient supply of beds. In spite of the usual efficiency of Hospital Standards Committees, the many patients with long term illness constitute a real barrier to the full use of active treatment services. □

Reference

1. Gordon, P. C., "Characteristics of Patients in Long Term Care Institutions in a Metropolitan Area of Nova Scotia", N. S. Medical *Bulletin*, January, 1965

FORTY YEARS AGO

From The Nova Scotia Medical *Bulletin*
February 1926

Medical Societies

Probably nothing gives a better indication of the healthy attitude of the profession in this province than the way in which in the last few years, our local societies have been organized and the interest that is being taken in them. At the present time, the province is pretty well covered with these societies and unless report is a lying jade, excellent work is being done by them in getting the local men together and the meetings are being enthusiastically attended. One of the great disadvantages of country practice is the difficulty men have of discussing their troubles. One of the great losses the profession as a whole suffers, is the fact that so many interesting cases met and dealt with successfully in the country, are never recorded. The local societies should help to remedy this.

At the present time, however, the tendency is for the societies to call outside men into their meetings and to let them do most of the talking. The outside man, often a specialist, is inclined to talk on subjects that, however fascinating to himself and his kind, do little frequently to illuminate the difficulties that beset the general practitioner. For instance, a paper on bronchoscopy, on brain tumours, on the value of myomectomy has little more than an academic interest for the average man in practice. He wants to how best to treat the common cold, how to handle an acute abdomen, how to treat a fracture in a private dwelling, how to feed the baby that is not thriving, how to deal with obstetric problems. These are matters to which, while the specialist can undoubtedly bring much enlightenment, the man who has been up against the difficulties and surmounted them in a successful and practical way far from hospitals and the help of nurses can often bring more. It is all very well to have someone describe the great value of Caesarian Section in central placenta praevia, but what does one do when one meets it of a dark blizzardy night ten miles from home? □

Municipal Mental Hospital Program
Province of Nova Scotia

G. Graham Simms, M.D., D.P.H.[1]
Halifax, N.S.

On the 30th day of March, 1965, the Legislature of the Province of Nova Scotia gave assent to a new Act known as the Municipal Mental Hospitals Act. It is understood that this Act will be proclaimed and therefore in effect, as of January 1, 1966.

The above Act is a most important one inasmuch as it will bring about a distinctly new and updated program of treatment and care for a relatively large group of patients who while not entirely neglected, nevertheless have been in a bit of a backwater away from the main stream of health care.

New Legislation

The Act, in brief, brings all eight Muncipal Mental Hospitals under the jurisdiction of the Hospital Insurance Commission. The authority and responsibility of the Commission has been established deliberately along parallel lines to public hospitals: the Commission approves construction changes and Provincial Construction Grants; the Commission determines the amounts to be paid in respect of the provision of services in hospitals; and finally the Commission is responsible for encouraging and promoting the development and maintenance of a co-ordinated system of Municipal Mental Hospitals throughout the Province.

There are other important provisions under this Act.

Having in mind that the Board of a hospital is morally and legally responsible for the standard of care in a hospital, it is obviously of the greatest importance that hospital boards be so composed and so function that this grave responsibility may be discharged properly and effectively. The Municipal Mental Hospitals Act provides that the Board shall consist of eleven persons of whom seven shall be appointed by the Council of the Municipality that owns the hospital, and four by the Governor-in-Council. Further not fewer than three of the persons appointed to a Board by the Council of the Municipality may be persons who are not members of the Council. Each member of a Board holds office for a term of not greater than three years, although at the expiry of his term he is eligible for re-appointment. These provisions go far to ensuring a broadly representative governing body.

Following the passage of the Act, the necessary extensive and intensive program of preparation for the implementation of the Act was initiated. This included among other things regular meetings between the Departments of Welfare, Health and the Commission to co-ordinate action, as there are quite major Welfare and Health factors involved. Visits to certain key psychiatric centres* in the United States and Canada were made by Dr. C. S. Marshall, Administrator, Mental Health Services, Department of Public Health and the author, accompanied by Dr. J. H. Brown of the Department of Psychiatry, Dalhousie University, and Dr. J. M. Tainsh, Administrator, Halifax Mental Hospital. Medical assessment by an attending psychiatrist of all patients in Municipal Mental Hospitals, and appointment and activation of a highly qualified Medical Advisory Committee,★ helped prepare for this new program.

Regulations

Regulations under the Act were developed and approved by the Governor-in-Council. Those parts of the Regulations which are of particular interest to the profession are as follows:

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[1]Vice-Chairman and Executive Director, Nova Scotia Hospital Insurance Commission.

*Massachusetts Mental Health Centre, Boston
Boston State Hospital, Boston
Haverford State Hospital, Pennsylvania
Fort Logan, Denver, Colorado
Yorkton Psychiatric Centre, Saskatchewan
The Ontario Hospital, Toronto, Ontario

★Dr. C. S. Marshall (Chairman)
Dr. J. A. MacDonald
Dr. F. R. Townsend
Dr. Harry Poulos
Dr. R. O. Jones
Dr. C. Donovan
Dr. D. O. Lynch
Dr. J. H. Brown

"Payments to Municipalities

2. The Commission shall approve payment to a municipality in respect of operating expenses incurred by it in providing treatment, maintenance and care in a hospital to a patient, if the Commission is satisfied:
   a) awhen the services were provided the patient was mentally ill to a degree requiring hospital treatment and care;
   b) the hospital is so constructed, equipped, staffed and operated that a satisfactory standard of treatment and care is provided to patients; and
   c) the board and the municipality comply with these Regulations."

"Standards Control

11. 1. The superintendent of a hospital, if required by the Commission, shall forward to the Commission, within forty-eight hours after each patient is admitted, a notification of admission of the patient in the form prescribed.
    2. The superintendent of every hospital shall forward to the Commission within four days after each patient is discharged from or dies in the hospital a notification of discharge or death, in the form prescribed.
    3. When a person has been an in-patient in a hospital for 30 consecutive days, the superintendent of the hospital shall forward to the Commission a Long Stay Report, in the prescribed form, respecting the patient, within four days after the expiry of the 30 days and after every subsequent ninety day period during which the patient remains in hospital.
    4. Not later than the fifteenth day of every month, the superintendent of every hospital shall forward to the Commission a report, in the prescribed form, with respect to out-patient services in the preceding month.

Standards Committees

12. To provide for the effective utilization of in-patient and out-patient services in hospitals, there shall be set up Hospital Standards Committees and a Provincial Standards Committee.

Hospital Standards Committee

13. 1. In every hospital there shall be set up by the board, a Hospital Standards Committee of not fewer than three persons, including the superintendent, a member of the board, and a member of the medical staff. The function of this Committee shall be to assist and advise the hospital board in developing and maintaining high standards of service, and reasonable and proper utilization of services.
    2. The members of a Hospital Standards Committee who are members of the Medical Staff, together with such other members of the Medical Staff as are appointed by that staff, shall constitute a Medical Sub-Committee whose function shall be, to study matters primarily of a medical nature, and to report to and advise the Hospital Standard Committee on such matters.
    3. The Hospital Standards Committee shall review monthly, admission, length of patient stay, drug usage, diagnostic services, nursing services and all other matters having to do with the standard of services and the utilization of services in the hospital.
    4. The Hospital Standards Committee shall advise forthwith the hospital board if, in the opinion of the Committee, the standard of any service is unsatisfactory or the utilization of any service provided by the hospital is not reasonable and proper.

Provincial Standards Committee

14. 1. The Commission in whole or in part, shall act as a Provincial Standards Committee to ensure, insofar as is possible, the development and maintenance of a high standard of hospital services and reasonable and proper utilization of hospital services in all hospitals of the Province.
    2. To assist the Provincial Standards Committee in carrying out its function, the Commission may appoint a Medical Advisory Committee."

The total program which is to become effective January 1, 1966 will be phased to provide for a period of adjustment and subsequent orderly development.

The Commission in principle and in accord with the Regulations, would be prepared to approve payments to municipalities related to expenditures incurred by them in providing treatment, maintenance and care to mentally ill patients requiring such treatment and care in the Cape Breton County Hospital, the Halifax County Hospital, the Halifax Mental Hospital and the Kings County Hospital.

The Department of Public Health which up until January 1, 1966 will be responsible for the payment of certain costs, will continue to provide assistance to certain other categories of personnel in a number of the Municipal Mental Hospitals; this assistance is to cover a transition period plus allowing for adjustment by way of transfers, etc., up until July 1, 1966.

On October 12th and 13th, a Hospital Insurance Institute was held in Halifax at which were present key representatives from the above mentioned four hospitals: Chairman of the Board, Administrator, Medical Staff and Accountant; and representatives of the Departments of Public Health, Public Welfare, Municipal Affairs, and the Department of Psychiatry of Dalhousie University. The purpose of the Institute was to review the proposed program which is to go into effect January 1, 1966, and to have the benefit of the comments and advice of the representatives present. The Institute was interesting and productive.

The foregoing is a very brief summary of what is in fact an important and quite complex program; it is important because it means a "new deal" for a group of patients who in most places and at most times have been classified as "backward" and largely forgotten. The quite startling results from better care now obtained in some centres make this previous situation only the more regrettable. It is a complex problem because the dividing line between certain sub-groups tends to be sufficiently fine and arbitrary that only the greatest care and co-operation, which is being manifested by all concerned, will prevent further "injustices" to some groups of these patients. □

Coordinated Home Care

PETER C. GORDON, B.Sc., M.D., C.M., D.P.H.[1]

Halifax, N. S.

The increasing number of chronically ill and aged persons in our population is placing heavy demands on our general hospital facilities. Recognizing that general hospitals are primarily oriented to the treatment of acute illness, various alternative services have been proposed, and instituted in other areas, for the purpose of improving the quality of care, for those with long term illness. One of these alternative services is coordinated, or organized, home care. The Royal Commission or Health Services recommended "that every hospital in Canada of 100 beds or more introduce either independently, or in association with other hospitals in the same centre, other community organizations, the local health department, or any combination of these, a home care program".(1) In Nova Scotia there are 26 hospitals with 100 beds or more. There is apparently, then, considerable potential for the development of coordinated home care in this area.

In one form or another, home care has been practised as long as there have been homes and people have been sick. The usual pattern of home care, involving the patient's family, the doctor and the visiting nurse, still provides all the care requirements of most home-bound patients. However, many chronically ill patients require additional services, which are traditionally provided only in hospitals or by a multitude of often uncoordinated and fragmented community agencies. Coordinated home care programs have thus been developed, in order to provide the administrative structure, through which many of these services can be brought to the patient in his home. Coordinated home care, in contrast to the usual pattern of home care, is therefore "centrally administered and through coordinated planning, evaluation and follow-up procedures provides for physician-directed medical, nursing, social and related services to selected patients at home".(2)

Criteria for Coordinated Home Care

In their fullest development, coordinated home care programs meet the following criteria, which are largely based on a presentation to the American Public Health Association in 1962 by Jack Kasten.(3)

1. As an administrative unit, the home care program accepts the responsibility for seeing that all medical and related service needs, within the scope of the program, are met.

2. There is a formally-structured team comprised of at least a physician, a public health nurse, and a social worker, responsible for conducting the program. This team is responsible for evaluating referrals to the program, to determine suitability, and for reviewing the progress of the patients, at least monthly, through a record review conference.

3. A medical record is kept for each patient similar to in-hospital patient records.

4. The range of home services coordinated, through the program's administrative staff, include, in addition to physician's, nurse's and social worker's services the following:

   a Homemaker services
   b Physiotherapy and occupational therapy
   c Laboratory services, including technician home visits
   d Electrocardiography
   e Inhalation therapy
   f Nutritional services, including "meals on wheels"
   g Appliances, including hospital beds
   h Speech therapy
   i Drugs and other medical supplies
   j Dental services

Some programs go even beyond this and provide home visits by hairdressers, friendly visitors, podiatry services, ambulance and taxi services, etc. In fact, the range of services offered is only limited by their presence in the community and their willingness to cooperate in the program.

5. An in-patient hospital bed is available and guaranteed if the patient's condition deteriorates to the extent that home care is no longer appropriate.

6. The homes selected as suitable for this type of care provide an environment that is physically and socially appropriate for the purpose.

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[1]Assistant Professor of Preventive Medicine, Dalhousie University, Halifax, Nova Scotia.

7. The program constitutes primarily a service medium but may also provide an effective learning experience for the medical student, intern and resident in the practice of community medicine.

Implications of the above criteria

The above criteria have many implications. First, it is apparent that not all patients require, or are suitable for, coordinated home care. They constitute carefully selected patients, requiring comprehensive care, involving a number of closely coordinated services and agencies. Generally, they are "hospital type patients" who are suitable to receive "hospital type care" at home. If this type of care is not appropriate, as determined by the evaluation team, the patient may remain in hospital or be referred to another facility or service, offering the individual services he requires. Coordinated home care should not be a relatively expensive form deluxe home service for patients requiring only nursing care, nor for ambulatory patients who can receive the care they need in the physician's office.

Second, services required must obviously be present and available in the hospitals and community and their scope and capacity should be carefully assessed prior to the introduction of the program. Obviously, not all the above listed services are presently available in all the communities with hospitals of 100 beds or more in Nova Scotia. Programs can be instituted, with only a few of these services, however, and others added. as the program evolves, and the need for additional services is demonstrated.

Third, the cooperation of the physicians in the area is vital to the success of the program. After reviewing home care programs in North America, Dr. Genesove concluded that "the biggest single failing in each program was the failure to enlist the support, develop the interest, and utilize the skill of the average neighbourhood physician".(4) Thus, the local family physicians and hospital staffs must be intimately involved in the planning and operation of any program. It is essential that the physicians in the area become convinced that the program can offer their patients, and themselves, advantages which the present pattern of hospital and community services cannot.

Fourth, the criteria require central administration and coordination, the keeping of medical records and regular team conferences, which include the attending physician. All these imply continuity of care, and some degree of regulation and evaluation of the quality of care provided. If the primary purpose of coordinated home care is to improve the quality of patient care in a home setting, and if the above listed criteria are met, or at least set as goals, then some form of regulation is obviously necessary. Central in planning for home care, then, is the issue of where the administration of the program should be based, in order to provide, most effectively, the coordination and regulation required.

The Administrative Base for Coordinated Home Care

These programs may be either hospital or community based. In hospital care, whether it be in the acute care wards, the chronic care section or the out-patient department, medical and related services are subject to regulations which have largely been drawn up and enforced by the medical staff, themselves. John Thompson(5) has therefore made a strong case for the hospital-based program in pointing out that "the hospital is the only agency at this time which is capable of regulating and combining the medical, nursing, social service and ancillary service components of a home care program". Stressing the point that coordinated home care is "hospital type medical care" given in the home, Thompson defined this as a kind of medical care that is characterized by organization, supervision and a genuine concern for quality. He feels, therefore, that the home care staff should be organized along lines similar to those of a hospital staff. Further, a hospital-based program is at the primary source of referrals and is best able to ensure the availability of a hospital bed for the home care patient when it is required.

Thompson reviewed the causes of the failure of a home care program in New Haven, Connecticut. There were two hospitals in the city, one operated by a religious organization and the other, the main teaching hospital of the University, neither of which was interested in administering the program. Thompson felt that the primary cause for the program's failure was the inability of the visiting nurse association, which administered this community-based program, to really coordinate the medical component. There was a lack of liaison between the home care program, the two hospitals and the local medical society. "Because of this weakness, that which resulted was not a home care program but merely a "beefed-up" visiting nurse program. It offered the physician nothing more than was present before though it may have been in a more convenient package".(5)

The prototype of the highly organized hospital-based programs is the Montefiore Hospital Program in the Bronx, New York.(6) This program provides excellent, comprehensive, personalized care to selected indigent patients. All patients on the program are under the care of five internists attached to the active hospital staff. It has been criticized, however, because it has not expanded to include other than indigent persons and because the local family physicians have not been enabled to participate in the program. A similar type of program is operated by the Beth Israel

Hospital in Boston. Its administrator refers to his program as another ward of the hospital out in the community.

The primary reasons offered for basing the home care program on a community agency, are that the program is able to offer the service to patients prior to their admission to hospital, and to extend the service over a wide geographic area. In fact, however, most of the patients admitted to these programs have been referred directly from hospital. Depending on physician cooperation for referrals, and involving the local Medical Society in their planning and organization, they usually have a senior physician on the administrative team. In order to increase their caseload it has been necessary to engage in active case finding.The program in Toronto,(7) operated by the health department and the one in Detroit,(8) administered by the Visiting Nurse Association, for example, have "nurse coordinators" located in the cooperating hospitals, who search the wards for cases potentially suitable for coordinated home care. It has been found that the caseloads of these programs vary directly with the activity of the nurse coordinators.

The Greenwich Hospital Association Program(9) and the Moose Jaw Community Home Care Program(4) have been able to enlist the support and skill of the practising physicians and combine some of the best features of both hospital and community-based programs. In the Greenwich program, there is a hospital-based home care team consisting of the following personnel:

1. A physician coordinator who is responsible for integrating the services requested by the patient's family physician.
2. A nurse who participates in the evaluation of the patient's nursing needs and the adaptability of the home to meet these needs.
3. A social worker who participates in the comprehensive evaluation of the patients and their families and assesses the readiness of the patient to accept home care and the family's willingness to give such care.
4. A physical therapist and an occupational therapist who carry out the orders of the attending physician when their services are required.

All patients admitted to the program are first evaluated by this central team. As the program has the active support of the hospital medical staff, and is hospital-based, it has the control over quality of care that a hospital staff can exert and it has readily available all the resources of the hospital to extend out into the patients' homes. At the same time it has the support of the family physician and the community agencies. The cooperating agencies, as well as the physicians, were involved in the planning and organization of the program and can refer patients from outside the hospital to the assessment team.

In Moose Jaw, Saskatchewan, the home care program is administered by an executive board consisting of five general practitioners, appointed by, and responsible to, the district medical society. The regional director of the Victorian Order of Nurses and the executive director of the Family Service Association were appointed as two permanent consultants to the board. The executive board holds regular patient conferences with its permanent consultants, family doctors, visiting physiotherapist and nurse involved in the individual patient's care.

In a community with more than one general hospital, it has been held that it is more efficient to have a community-based program rather than two hospital-based programs. In Moose Jaw, however, there are two general hospitals and yet only one coordinated home care program. This has been accomplished by locating the administrative office in one hospital, and by sharing office space with the Victorian Order of Nurses, which is located in the other hospital. The services of the program are thus available to the entire community.

It is, therefore, apparent that there are a number of approaches to home care and each community must decide which is the most appropriate for its own particular area. However, the form it takes, in each area, will largely depend on the source of the effective leadership for its development, which may be the family practitioner, the hospital, health department, the Victorian Order of Nurses or other community agency.

Costs and Financing of Home Care

The per diem costs of four selected home care plans in Canada, as reviewed by the Royal Commission on Health Services, range from $1.59 to $7.44.(10) Estimates of per diem costs vary widely due to a lack of uniformity among the plans as to the services provided, patients accepted, administrative arrangements and auspices. In addition, administrative costs, and costs of drugs and services provided by community agencies may, or may not, be included. Using direct cost accounting methods, which included all indirect costs, Gee(11) calculated the per diem cost of home care, under the auspices of the Jewish Hospital of Saint Louis, as $4.82 for 1962.

Direct comparison of the costs of home care with that of hospital care is difficult and often not realistic. Direct comparison assumes that the two types of care are equivalent and the basis for cost accounting is similar, which is only true if home care is, in fact, a continuation of equivalent hospital care. It is quite possible that the home care per diem cost would be higher, were it calculated separately for the days actually substituting for hospital days.

One of the obstacles to the development of home care plans is the problem of adequate financing. In some areas, such as in Detroit and New York City, the Blue Cross Organization pays for home care services for up to a certain maximum number of days. In other areas, the plans have been financed by special Government grants, usually for only a limited demonstration period. In Canada, however, the Royal Commission on Health Services pointed out that "as long as the cost of hospitalization is covered by the insurance plan, but the patient is expected to pay for services such as home care received outside the hospital, there is an incentive to use the hospital even where adequte care can be provided outside".(12) This deterrent to the development and use of home care would, of course, be eliminated if the Commission's recommendations are implemented.

The recent amendments to the Social Security Act in the United States are of particular interest in this regard. Under the compulsory Hospital Insurance Program, the amendments provide for up to 100 post-hospital home health visits, on a full-service basis, within one year after the patient is discharged from hospital, after at least a three-day stay, or from a participating extended care unit, which includes skilled nursing homes and rehabilitation units. Insured services are limited to those 65 years of age and over and include nursing care, physical, occupational and speech therapy, medical social services, medical supplies, appliances and the home services of internes and residents under an approved teaching program of a hospital, with which the home care administration is affiliated. "The less expensive alternatives to in-patient hospital care are intended to promote the most efficient and economical use of existing health-care facilities while enabling the beneficiaries to have the kinds of services and levels of care most appropriate to their needs".(13) Under the voluntary phase of the new program, referred to as Supplementary Medical Insurance, home health visits, including physicians visits, are provided without the requirement of prior hospitalization. It is expected that these provisions will greatly stimulate the formation of home care plans in the United States. It might be anticipated that forthcoming similar, or even more extensive, developments in the area of health services insurance in Canada will have similar results.

Summary: -

Coordinated home care programs are advocated as one of the alternative services which can help to relieve the pressure on hospitals and, at the same time, provide high quality care for persons with long term illness. The Royal Commission on Health Services has recommended that home care programs be introduced in every hospital with 100 beds or more. Providing comprehensive, co-ordinated, services under the direction of a physician these programs may be administered under the auspices of a hospital or a community agency. A number of programs, using different approaches to home care, are discussed. Recent amendments to the Social Security Act in the United States and anticipated development in health services insurance in Canada may stimulate the further development of home care plans. □

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New Nursing Home Standards in Nova Scotia

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Halifax, N. S.

In 1958 we were fortunate in having a Nursing Homes Act passed in the Legislature. The author was named Chief Inspector of Nursing Homes and the Health Unit Directors were made local inspectors. On first glance, it is a little difficult to assess fully the effect the Act had on the nursing home problem. Some will say it had very little effect because we still have some "hell holes" calling themselves nursing homes. That is true. However, on the other hand, it began to focus public opinion on the problems of the older age group. It influenced one individual in Armdale to build a one hundred bed nursing home that is just as modern as you will find anywhere. It provided a forum where interested people could come to discuss their aims and ideals, and receive encouragement and a modest degree of assistance with the financial aspects of their project. It provided an avenue whereby prospective operators could be acquainted with the needs of the geriatric patient, and the facilities required for an efficient operation pointed out. It may be said that the facilities required bear little relation to existing regulations because the regulations, of necessity, must be minimal.

The criticism has been made that one should not expect too high a standard from nursing homes because it makes the price too high to the consumer. This is not the experience of our Department. Efficiency and economy go hand in hand.

We have been asked to review a few items which may be common knowledge to most physicians and rank repetition to some of you. However, they are the frame-work on which nursing home regulations must be built. Your understanding will help give this program to improve nursing home care for your patients the support it needs.

What types of care are needed by persons of all ages, but especially the elderly, who may meet criteria for admission to a nursing home? They may be classified as:

1. personal care
2. chronic illness care
3. convalescent care,
4. rehabilitative care

Several or all these types of care may be needed by every nursing home patient, in succession or concurrently. Regardless of which classifications they fall into, all nursing home patients have certain basic common needs. These are:

(i) housing
(ii) fire protection
(iii) adequate living space
(iv) good nutrition
(v) "tender loving care"

Those in classes 2, 3, and 4 also need

(vi) professional nursing care

Those needing personal care only, and some of the more seriously ill or with specialized needs, may require care in other institutions, but the regulations governing nursing homes must try to set standards for these items at least.

Housing

In establishing housing standards we must be prepared to think of the small home taking four patients or the large installation providing accommodation for one, two or three hundred patients. In this consideration, we must think that these people are you and I a few years hence. The thought that these people will be going to these institutions to live, not to await death, must be paramount. Therefore, there should be an avoidance of isolation. These people do not want to be carried off miles from friends and visitors. If ambulatory, they should be able to visit in a neighbourhood, go to the bank, the store, the church, etc. They must not be confined to their own rooms. They must have recreation space; a place for card games, afternoon tea, the laughter of a stitch and chatter group and the warmth that comes from the convivial exchange of thoughts and reminiscences. The elderly person should be responsible for himself as far as possible. "If treated like a child, he will become childish and let others do for him. We act as we are expected to act - and the patient is no exception to this." Buildings must be designed to aid patients to be mobile and self sufficient as long as possible; and also designed to aid in the re-establishment of function where possible. Regulations in this regard must adhere

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to the various building codes, both national and local, as well as the Canadian Building Standards Guide material.

Fire Protection

When it comes to fire protection, obviously regulations must be most stringent. This is a matter for the Fire Marshal, and the Health Department can accept no deviation from his directions.

Overcrowding

The third item, adequate living space, or absence from overcrowding, requires a lot of consideration. Rooms with many beds do not add anything to human dignity. The big dormitory should be frowned on. The four-bed ward or the two-bed-room should provide screening for privacy. There is an appropriate quotation which says that "we have added years to man's life, but these institutions must provide life for these years".

Nutrition

Good nutrition is a necessity. It is in this domain that we find many discrepancies. Plans for new construction or renovation of kitchens should be submitted to the licensing body before work is commenced. They should conform to municipal eating establishment by-laws where such exist. Standards for size of both kitchen and dining room should be laid down in regulations. Menus should be planned and recorded for inspection purposes. Cooks should be required to attend food handler courses as these develop across the Province.

Tender Loving Care

One needs only to read the article on "Nursing Homes" in the March Issue of Chatelaine to realize the need for "tender loving care".

Some elements of the training of nurses and other professional and non-professional personnel help reinforce and direct the natural human kindness that has been so greatly inhibited by our necessary preoccupation with scientific elements of medical and nursing care. The example of the attending physician and of the operators of the institution are also important. One can sense warmth and devotion in some institutions, and there is a growing literature on studies of whether care is "person centred". It seems beyond the scope of regulations for the most part, but is no less important or perhaps even susceptible to improvement for that reason.

Nursing Care

We have now discussed in generalities the needs of the overall geriatric group. This leaves only the needs for professional nursing care. Experience elsewhere emphasizes the need in this regard of a close relationship of nursing homes with hospitals. The hospital in some ways is the nurses' workshop and the doctors' workshop. The doctor's workshop is the operating room, the case room, the X-ray department and the laboratory. Subtract these services and you are left with the nursing unit. A nursing staff can nurse a thirty-bed unit most efficiently. This is a crude rule of thumb for planning. The room sizes in the unit should have a minimum of 80 sq. ft. per person in multiple bedrooms, and a minimum of 100 sq. ft. in single rooms. These minima are small for long-stay patients. The unit should have an isolation suite consisting of two single rooms with either a common or separate subutility. There should be separate clean and dirty utility rooms, examination and treatment rooms, janitor's closet, stretcher and wheelchair bays, laundry storage, toilet and bath outlets, nurses' station, nurses' washroom, floor pantry, and certain other minimal services.

More recent legislation will make it possible to improve and extend these standards.

Current Situation and Progress

During the past summer, the Health Unit Directors were involved in a study of the private unlicensed nursing homes in their Health Units. This was an effort to have an up-to-date picture of the geriatric facilities in the Province. It was necessary as a guide to future programming. It was necessary also to have a picture of the problem before preparing new regulations. And finally, it was necessary in order to assess the legal responsibilities of the Department as far as these unlicensed facilities are concerned.

In the past it was simple for an operator to say that he was operating a boarding home rather than a nursing home. Now there is an Act Respecting the Licensing of Boarding Homes Providing Special Care. This Act will be administered by the Department of Public Welfare. There will be a co-operative effort by both Departments in the interest of the older citizen. In criteria for admission and standards for care the home will have to meet either the standards of a nursing home or the standards of a boarding home.

The Health Unit Directors examined sixty-eight geriatric caring institutions. In these institutions there were 857 beds. Overcrowding was demonstrated in 40 homes. Although most of these homes had some patients requiring nursing care, only 12 provided the services of a registered nurse. Ten more of the institutions had a certified nursing assistant as their source of professional nursing care. Only 29 institutions provided satisfactory kitchen facilities. Twenty institutions did not supply sufficient toilets for their patients. *Only three homes out of 68 showed reasonable fire protection.* The overall rating by the Health Unit Directors showed -

23 good
38 fair
7 poor

It seems clear that the seven poor homes should be closed. If time and staff were available, some work should be done with the remainder. However, the ultimate cure will come with new construction. Today we have 10 institutions with three hundred and four licensed nursing home beds. In Yarmouth, the Villa St. Joseph du-Lac is presently applying for license and is coming up to the standard. Annapolis County is building a new municipal home, a third of whose beds, 25 to be specific, will be nursing home calibre. In Windsor, the United Church is building a new multiphasic home with a third of its beds nursing home beds. In Caledonia, a thirty bed nursing home is nearing completion. This one will be unique insofar as it also has cottage hospital facilities as well. In Halifax you may have noticed the St. Vincent's Guest House rising above the other buildings at the Willow Tree. It will have 148 beds, a third of which will be nursing home beds. Keddy's Nursing Home of 100 beds is now open at Armdale.

Active planning is proceeding on a replacement of some 300 beds for Basinview by the City of Halifax; one-third of which will be nursing home beds. A similar sized replacement is now on the drawing boards for Oceanview by Halifax County. Antigonish has a one hundred bed nursing home in the talking stage. Preliminary drawings are completed to replace a private non-licensed nursing home in Amherst. Preliminary drawings for 150 beds for a private nursing home in Sydney are progressing. Preliminary drawings for a seventy-five bed multiphasic institution to replace St. Anthony's home in Sydney are progressing favorably. Many less advanced projects have been submitted for consideration recently, and I hope that they will come to fruition in the future.

Summary

The place of the nursing home among the institutions and services for long-term care, especially for the aged, is becoming more clear in Nova Scotia. Minimum standards now provide a basis for better services. New construction and parallel standards for boarding homes and other types of institutions, promise great improvement in care.

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Now is the Time

HUGH MARTIN M.D.

Sydney Mine, N. S.

"My Story Is Not Long, But It Took A
Long Time To Make It Short"
"Thoreau"

The season of Advent, the season of the coming, in this case, of Medicare, is well advanced but there is still time for the Medical Profession, through the C.M.A. to tell the people in the language of The People, what to expect under proposed Medicare.

If Government tells The People that under Medicare they will have no more Doctor's bills to pay it sounds wonderful. So the Medical Profession should start **now** telling The People what they may expect under Medicare. Tell The People or even spell out in the most understandable way that it is not going to be a case of "Getting Something for Nothing".

There is an old truism, as true as it is old, "Nobody Gets Something for Nothing".

Our short experience with so-called free hospitalization tells us in simple language two things: First, it is not free. We pay for it here in Nova Scotia by a sales tax. Second, it is true you do not have to pay for a ward bed in hospital, but try and get a bed in hospital. So it turns out to be a mirage. Instead of "Getting Something for Nothing" you get "Nothing for Something".

The same may be true if Medicare is introduced to cover everybody.

You will not have to pay any Doctor bills, all you have to do is get a Medical Doctor to "Deliver The Goods".

At this stage I would like to use a Parable to describe The Medical Profession. Our Lord spoke to His People in Parables, so what is good enough for God is good enough for me.

THE PARABLE

I would liken the Medical Profession to a good tree. A good tree is one growing on good sound fertile ground from which a good source of the life blood of the tree is brought up into a good firm trunk, from where it is distributed to the branches to obtain good healthy symmetrical branches. The **trunk** is a Doctor of Medicine. The **Branches are the specialties:** Surgery, Internal Medicine, Anaesthesiology, Administration, Urology, Pathology, Radiology, plus the various Colleges.

The trunk, (Doctor of Medicine) without branches would be a *bare tree.* The branches, without the trunk would be an *impossibility.*

One branch should not be allowed to grow too big, because even though it may be good and desirable, it draws too much of the life blood from the main trunk and thus weakens the whole tree and its symmetry so it should be pruned to restore the symmetry and allow the life blood of the main trunk to maintain the whole structure of the tree and its symmetry.

END OF PARABLE

One branch that grew too big is the Royal College of Physicians and Surgeons of Canada. It was started in a small way by a group of eminent Physicians and Surgeons. At first it was easy to attain Certification, but as it grew, the prescribed years of *Formal Training* was increased in order to qualify to even sit for the examinations. If you did not have the prescribed number of years of *Formal Training* (informal training was never recognized) by the College, your chances of passing the examinations were quite hopeless. Thus the possession of Certification or Fellowship in the Royal College of Physicians and Surgeons of Canada became too large, so large as to create another trunk and so created in the Public Eye two classes of Doctors of Medicine. (Those With and Those without connections with The Royal College of Canada.) Even though it was good it served to weaken the Medical Profession by dividing it into two classes of Doctors, in the minds of The People.

Have you ever gone into the woods looking for a good Christmas tree? How many times have you seen from a distance a good looking symmetrical tree only to discover when you got close to it that the reason why it looked so good from a distance was that it had two trunks. Divide it and you only have good branches on one side.

At this time we should explain to The People that a College and a University are not the same thing. It was unfortunate for The People, and

their misinterpretation is understandable, that the Royal Colleges of Surgeons of Canada, England and Edinburgh and the American College of Surgeons, all chose the word "College". The man on the street boasts justifiably, that his son is going to College at Dalhousie or that he has a College degree. The University degree is valuable. Colleges do not confer degrees, they just add prestige and more initials after the Doctor's name.

The success of the Royal College spawned Colleges of Physicians and Surgeons in every Province of Canada except the Atlantic Provinces.

These Colleges serve a useful purpose in self-government of the Medical Profession as to discipling its members and acting as a licensing body for the Doctors.

The most important thing any person can possess is good health. All else follows. *Just as a person cannot buy good health with money alone, neither can a collection of individuals, which is a Nation, buy good health with money alone.* We must have Doctors of Medicine, not divided into two classes as they are now, the Specialist and the G.P., two classes that The People have been led to believe, exist.

We should explain to The People that the Specialist is not a superior Doctor and the G.P. not an inferior one.

It is true the Specialist knows more about his particular field than the G.P. does, but just like rows of railway tracks, the tracks of the Specialist in his field, are shiny because they are used constantly, while other tracks for which he studied hard and learned about in Medical School, have become rusty from disuse. The tracks of the G.P. are not shiny but they are not as rusty as those of the Specialist because of their use to some extent.

The Medical Profession across this Nation is dedicated to the provision of Quality Medical Care. To provide this we must have good Doctors.

I stated that the Specialist is not necessarily a superior Doctor and the G.P. an inferior one, but there are superior and inferior Doctors in the two groups.

Quality Medical Care will never deteriorate as long as the Doctor has above all, honesty, integrity and good judgment besides a thorough up to date knowledge of the human mechanism and the ability to blow this knowledge up to see what it is made of.

The good Doctor will see to it that the best possible advice and treatment are administered by the Doctor of Medicine who restricts his practice to a Specialty for a particular field in a particular case, and the Specialist must have the same honesty and integrity to call in, or pass the case on to another who is better qualified, if need be, not necessarily by a diploma on his wall, but by his known ability.

The commttees' report set up to establish a self-governing body for Nova Scotia was approved in principle by the executive of The Medical Society of Nova Scotia. Approval in principle, a fancy way of avoiding making a decision is the wrong way. It is the same as "Sitting on it" until the next annual meeting. The committee should have been given a further mandate to proceed with the setting up of this self-governing body, as it will take time.

I would suggest calling this self-governing body "The **Society** or **Association** of Doctors of Medicine of Nova Scotia" *not another College.*

It would be "Our Union", a word that is undignified for our noble Profession but would have the same effect, since all the Doctors in Nova Scotia would have to belong to it in order to have a license to practice medicine here. It would not displace The Medical Society of Nova Scotia which is a branch of the C.M.A. to which all Doctors do not belong, nor would it displace the Provincial Medical Board which would function for government. It would be a representative body for the Doctors and it should be set up as soon as possible to work with our Provincial Government.

By now it must be apparent that, in my opinion, three words which are misleading to The People should be changed:

1. Specialist
2. G.P.
3. College

I would suggest that a Specialist be known as a Doctor of Medicine restricting his practice, if he wishes, to one or more specialties.

Second, I would suggest that the name General Practitioner, G.P., or Family Doctor, have the more distinguished name of *Doctor of Medicine.*

I started Medical Practice in the hungry thirties under a compulsory Medicare. It was then known as the "check-off" system, in a mining town in Cape Breton, whereby it was a condition of employment that the miner had to designate a Doctor of his choice to whom the stipend, taken out of his weekly salary, was paid directly every week.

This system lowered the Coal Company's assessment to the Workman's Compensation Board as the workman was paying the Doctor.

When the Compensation Board changed its act about five years ago, so that all the employers had to pay the medical expenses of their employees for all accidents, the Coal Company then stopped the compulsory part of the "check-off" system.

WE then abolished the check-off system and *we were happy about it.* We got our bodies and souls back for a dollar a week. The workman saved his dollar a week check-off payment but most of them were very unhappy. *They saved their dollar but they "lost their whip".*

I know, *I was there.* I had about twenty-five years experience under the check-off system or compulsory Medicare, call it what you will.

In those days the supply of Doctors was greater than the demand for them in areas where this system did not exist but most of the Doctors in the areas where it did exist died early in life from overwork and frustration. Death is not so bad, but the tired, sick or frustrated Doctor is temporarily not a good Doctor, and people may get hurt, remembering "*Mens Sana Corpore Sano*".

Project this experience, which is just the old infallible law of Supply and Demand, to Compulsory Medicare for all, today, and we may find with the demand for Doctors exceeding the supply now, "The *Needy* Ones Again Will Have To Wait Until The *Greedy* Are Cared For".

Today the demand for Doctors exceeds the availability of Doctors as it is. So we must explain to The People that under a system of Compulsory Medicare they may be much worse off than they are today. As the late movie actor, Humphrey Bogart, said while dying with a cancer of the larnyx, "All We Have Is Money".

It is true that this is the sixties and Medical services have changed, but people do not change. The income tax as it is now, along with the increase in cost of living in this inflationary period leaves The People of the sixties in about the same financial condition as they were in the hungry thirties, when a dollar was a dollar and the income tax a minor factor, as compared with today.

Today's spectacular advances in Medicine owes much to the advances of *Yesterday's Today* and will contribute much to the advances of *To-morrow's Today* and so on, until the end of time, until, if ever, we can learn, through research and study, how God created us to function in the first place.

The Hall Commission recommends increasing the supply of Doctors of Medicine to look after the expected increase in demand under Medicare.

To recommend the Supply of Doctors is not unlike Mohammed commanding the mountain to come to him, when, of course, it would not come he philosophically said, "*If the Mountain will not come to Mohammed, Mohammed will go to the Mountain*".

To supply more Doctors is the Mountain. So we will have to explain to The People that the demand for services be reasonable so that those in true need and catastrophic cases be cared for first.

Today the Specialists are dividing into Specialists for Children and Specialists for Adults. There is nothing wrong with this as long as it is explained to The People.

We are not only dividing ourselves to be conquered, we are cutting ourselves into little pieces.

So I repeat - we must tell our side of the story directly to The People in the simplest language of The People.

I would also like to repeat that we should set up, as soon as possible, a self-governing body in this Province. Under it all Doctors would have to be licensed as well as disciplined, in order to practice in Nova Scotia.

I would prefer that the word "College" not be used, as it creates a false impression in the minds of The People. "A rose by any other name would smell as sweet".

Light a fire and the glow from that fire might stimulate others to restore the image of the Doctor of Medicine and to dispel the image of the Specialist as a special superior type of Doctor. Restore the image of the Doctor of Medicine, not two classes of them. All are Doctors of Medicine, some restricting their practice to a special field and others not necessarily restricting their practice.

The Ramifications of this theme are endless, and are as tempting to indulge in as sin itself, but over-indulgence in ANYTHING does not do ANY GOOD TO ANYONE. So I will close with a prayer that was published in The Nova Scotia Medical Bulletin.

A PHYSICIAN'S PRAYER

From too much zeal for the new and contempt for the old; from knowledge instead of wisdom; science instead of art; cleverness instead of common sense;

O Lord Deliver Us.

If this article should stimulate controversy amongst those who might happen to read it, its "mission will be accomplished". Controversy might stir up an awakening amongst our Doctors of the importance of setting up a Provincial Self-Governing body, which lay People, including Hospital Administrators, do not understand.

Certification by the Provincial Self-Governing bodies takes precedence over Certification by the Royal College of Canada. If you do not believe me, ask the Royal College.

"CONTROVERSY IS ONE OF THE SPICES OF LIFE" □

Comment

J. F. L. Woodbury, M.D.

Halifax, N. S.

Dr. Martin has done the Medical Profession a service by drawing its attention to the need for an organization with compulsory membership by all members of the practicing profession. Such an organization, call it what you will, should *elect* from its members an Executive (again, call it what you will) to "govern" the Medical Profession.

Surely we are not so somnolent that we are blissfully ignorant of the fact that the profession is changing so rapidly that it is necessary for our education to continue throughout our lifetimes. Surely it is obvious that this will cost money and that it would be unfair for the total cost of the education of the whole profession to fall upon the shoulders of those who choose to belong to the Medical Society. To say that the setting up of such an organization would lead to increased costs to each individual practising Medicine is true. However, if each physician is to have the lifetime educational process to which I have alluded above, he, or somebody, is going to have to pay for it. Indeed at present the members of the Medical Society of Nova Scotia are buying a certain amount of post-graduate education for the whole profession. The Provincial Medical Board may expend not more than one thousand five hundred dollars on post-graduate medical edcation each year, and, I believe, it cannot spend more without obtaining legislation to authorize it.

Can we delude ourselves that we are more saintly than the members of other professions? Is there, in fact, no need for an Executive that will deal with dishonesty, unprofessional behaviour, and incompetence? If there be one among us who has not heard the cries of dismay from Maritime Medical Care, who has not faced the problem of what to do about a colleague who has become mentally ill, addicted to drugs, or incompetent from lack of continuing medical education, let him measure the depths to which he has thrust his head into the sand.

Does the Medical Profession wish to discipline its own members, or does it wish to have discipline imposed upon it from outside?

At the Annual Meeting of the Council of the Medical Society of Nova Scotia, I had the honour to present a report written by an Ad Hoc Committee on Professional Self-government. Dr. P. J. Gouthro, Dr. J. C. Wickwire and Dr. S. C. Robinson and I were the Committee which prepared that report. The report recommended, among other things, "That a College of Physicians and Surgeons for Nova Scotia be set up. . . . . (in this respect the Committee agrees with the recommendations of the Hall Commission concerning Provincial Colleges of Physicians and Surgeons, which states, 'That in all Provinces the Colleges of Physicians and Surgeons be separately organized from the Provincial Division of the C.M.A., and that the power of all Provincial Medical Licensing Bodies be extended to give them sufficient authority to ensure that Medical and Surgical Practices of high quality'.)"

An objection was raised on the grounds that in one Province the "Provincial Medical Board or College had become so powerful that it had been necessary for certain groups of Doctors to organize into syndicates to resist it." No further information was given about the form of tyranny which we were led to presume the College must have practised.

The report of that Committee was referred to the Executive Committee of the Medical Society of Nova Scotia for further study. Presumably, then, the Executive should be studying this matter intensively, and should in the very near future either endorse or reject, in whole or in part, the recommendations of that Committee. One would suppose that the Executive, in its wisdom, would decide either to proceed in the direction of self-government of the profession by setting up an organization with compulsory membership by all practicing Physicians, or would recommend action to broaden the representation of the Medical Society on the Provincial Medical Board, and to extend the powers of that Board. One would hope that whatever body is to govern the Medical Profession would be exhorted to purchase a great deal more post-graduate education for Physicians.

One is indeed hopeful that the Executive Committee after its study of this matter, will **take action** and will not engage in the buck-passing and delaying tactics which are always available to those who prefer the status quo, no matter how dangerous. □

SUBSCRIPTION RATES

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Genetics and the Physician

P. L. Delva, M.D.

Kingston, Ont.

PART V

Polygenic Inheritance

Inherited characteristics that show *continuous* variation, stature, skin colour, intelligence, blood-pressure for instance, are controlled by several pairs of genes at different loci on one or more different chromosomes. If we consider stature for instance, there is no value between the tallest and shortest person that does not correspond to someone's height. It is an example of *polygenic* inheritance, as opposed to *monogenic* inheritance where the variation is *discontinuous* and follows an all or none law. Most traits, whether physiological, mental or morbid, show hereditable variation, usually polygenic.

Genotype, Phenotype, and Environment

We are the product of our genes (*genotype*) acting in our specific environment. The resulting end-product (*phenotype*) is thus the expression of both the genotype and the environment. Sometimes the environment has little influence on the genotype. Fingerprints, for instance, an example of polygenic inheritance, are finally and permanently determined by the fourth month of fetal life. Excluding gross malnutrition, stature provides an example in which the environmental component is relatively small. However, the great majority of traits show environmentally determined differences. It is difficult to unravel the genetic from the environmental component of a trait inherited polygenically: so much of the genetic component can be concealed. It is estimated for instance that the concealed genetic component is given by the formula $K - 1/K$, where K is the number of loci involved in a continuous variation: if ten loci are involved, 90 per cent of the genetic component will be hidden, if 100, 99 per cent. By selective inbreeding one can work out these problems in animals. Other methods are needed in man. To illustrate some of the difficulties involved in the elucidation of some of these problems, we will consider two examples, firstly the genetic component of a normal trait, blood pressure, and secondly the different components responsible for a rarer orthopedic abnormality, congenital dislocation of the hip.

The blood pressures of members of a "normal" random sample follow a normal distribution. We know, however, that the blood pressure of the relatives of patients with benign essential hypertension exceeds that of control relatives and also exceeds that of the random population sample. This is truer of the systolic than the diastolic pressure. In addition, the relatives of patients with primary malignant hypertension or with hypertension secondary to pyelonephritis apparently show a frequency distribution of pressures closely similar to that of relatives of patients with benign essential hypertension. It appears therefore that the systolic blood pressure is partly under polygenic control. It also appears that normal people included in the fourth quartile of our "normal" distribution may have benign essential hypertension, and that patients with primary malignant hypertension are represented in the right-handed tail. If this is so, then primary hypertension is simply a normal variation.

The genetic and environmental components responsible for congenital dislocation of the hip, long thought to be due to a dominant gene with reduced penetrance, have recently been redefined more accurately; three factors seem to be involved. The depth of the joint socket seems to be under *polygenic* control; the generalised laxity of the ligaments is a *monogenic* trait inherited in a dominant manner; and breech presentation with extended legs the *environmental* component so frequently present, completes the triad.

Twin Studies

Monozygotic twins arise from a single fertilised egg that divides into two separate genetically identical embryos; any difference between them is due to the environment. Dizygotic twins originate from different eggs fertilised at the same time by different sperms; they are genetically no more similar than ordinary brothers or sisters, but they share a more similar environment than their non-twin siblings. Twin studies have fascinated geneticists since Galton; they enable us to unravel the genetic from the environmental components involved in the etiology of disease. The Danish

study, not yet completed, has followed up 7,000 pairs born between 1870 and 1910, and concludes that genetic factors are unimportant in the etiology of malignancy, coronary occlusion, and peptic ulcer, but play some part in that of hypertension, cerebral apoplexy, mental deficiency, epilepsy, manic-depressive psychosis, tuberculosis, rheumatoid arthritis, rheumatic fever, bronchial asthma, and diabetes.

SUMMARY

In these five articles, I have tried to cover a few basic principles involved in modern human genetics. In a future series, I hope to cover human diseases in more detail, attempting to define the genetic and environmental components involved in their etiology. □

Rheumatoid Lung Disease

Among a large series of cases of rheumatoid arthritis, nine patients had diffuse pulmonary fibrosis. Pleuritis was the most common pulmonary lesion and dyspnea on exertion was an early clinical feature. Clubbing of the fingers and subcutaneous nodules were frequent, too.

Rheumatoid arthritis is a systemic disease characterized by pain and disability in peripheral joints. The disease may affect any organ but exhibits a strong preference for tissues abundant in mucopolysaccharide such as the joints and other serous surfaces, the eye, and the arteries.

The most typical histologic lesion is the necrobiotic granuloma. This histologic lesion is not completely specific, but is usually considered diagnostic of rheumatoid arthritis if the clinical manifestations of the illness are present.

An association observed between rheumatoid arthritis and lung disease has given rise to the term rheumatoid lung disease, but there is no well-defined concept of the relationship. The present study was undertaken to clarify this relationship.

Nine Cases Studied

Hospital records were reviewed of 702 patients diagnosed as having rheumatoid arthritis between 1950 and 1963 at the University of Arkansas Medical Center and Little Rock Consolidated Veterans Administration Hospital.

Patients were included in the study only if the roentgenogram showed moderate or severe diffuse pulmonary fibrosis. Of the 702 rheumatoid arthritis patients, diffuse fibrosis appeared in eight. A case from another hospital was added, to make nine in all. Subcutaneous nodules occurred in six of the patients, usually about the elbows and wrists.

Arthritis usually preceded the development of the pulmonary lesion. The interval between onset of arthritis and onset of pulmonary lesions ranged from 2 to 10 years in five patients. As for the other patients, respiratory symptoms were not present in two at the time chest abnormalities were discovered, and one patient developed pulmonary symptoms eight years prior to the onset of arthritis. There was no correlation between the severity of arthritis and the severity of pulmonary fibrosis. Four of the patients had severe crippling deformity of peripheral joints, two had moderate deformity, and three had mild deformities limited to the joints of the hands and wrists.

On the basis of chest roentgenograms, the fibrotic lesions in the lungs remained constant or increased in severity in all patients. There was no evidence that the infiltrative lesions ever regressed or that therapy altered the course of the pulmonary disease.

Results of pulmonary function studies were typical of cases of diffuse pulmonary fibrosis. The vital capacity was reduced; expiratory flow rates were normal.

The most common pulmonary lesion is pleuritis. It may occur with symptoms or be accompanied by pain in the chest. Although it often passes unnoticed, pleural effusion is frequently associated with pleuritis and may be detected if roentgenographic examination of the chest is done at the proper time. The episodes of pleuritis tend to be mild and transient, although they may be severe but in either event the result is fibrosis. Postmortem examinations often reveal dense pleural adhesions consisting of fibrous tissue without specific changes. The pleura, however, may contain typical rheumatoid granulomas with a central zone of fibrinoid necrosis surrounded by a fibrous layer of palisading connective-tissue cells and scattered mononuclear cells.

Histologic Changes

Interstitial pneumonitis tends to appear diffusely throughout the lung but may occur only in localized areas about the bronchi and blood vessels. The initial histologic event is dense lymphocytic infiltration with edema and thickening of the interalveolar septa. Lymphocytic foci resembling germinal follicles may be prominent, and the alveolar epithelium may be cuboidal. There is usually no intraalveolar exudate.

The clinical features in pulmonary fibrosis include the early appearance of dyspnea on exertion. Recurrent bronchitis with cough and sputum production and clubbing of the fingers are both common. Subcutaneous nodules are especially frequent, fine crackling rales are often heard, and cor pulmonale sometimes develops. Any degree of joint disability may occur. Total lung capacity is

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C. Dowell Patterson, M.D.: William E. Harville, M.D.; and John A. Pierce, M.D.; *Annals of Internal Medicine*, April, 1965.

[1]Reprinted from the Abstracts of the National Tuberculosis Association, Nov. 1965.
Printed through cooperation Nova Scotia Tuberculosis Association.

decreased because diffuse thickening of the alveolar walls alters the elastic properties of the lung. The resistance to expiratory air flow is usually normal but may be increased if the patient develops bronchitis or honeycomb lung. Otherwise, the physiological features are those of any sort of impaired diffusion or defective gas transfer.

Two types of pulmonary fibrosis occur in patients with rheumatoid disease - diffusely nodular and coarsely nodular. Necrobiotic granulomas are more common in coarsely nodular fibrosis but may occur in diffuse fibrosis as well. Not only do histologically typical rheumatoid granulomas appear deep in the lung parenchyma, but lymphocytic foci with dividing lymphoblasts occur which simulate germinal follicles. These findings are helpful in the differentiation of rheumatoid disease from other types of diffuse pulmonary fibrosis.

The central issue is whether the rheumatoid process results in lung disease in the absence of other pathogenic stimuli or the pathologic changes occur because the lung tissue is more reactive than usual.

The clinical course of patients with coarsely nodular pulmonary fibrosis is determined by the extent of the involved lung tissue. With extensive involvement the illness may be fatal, but in general it tends to be clinically less severe than diffuse fibrosis.

Rheumatoid lung disease encompasses a wide range of pathologic alterations, varying from insignificant fibrous pleural adhesions to progressive and fatal diffuse fibrosis. The high frequency of lung disease in rheumatoid patients suggests that the rheumatoid process is essential or at least important to its cause. But the lack of correlation between the intensity of the arthritis and the severity of the lung disease suggests that the rheumatoid process alone is not responsible for the lung involvement.

The exceptional reactivity of the lung tissue in patients with rheumatoid disease makes it seem reasonable to propose that ordinary pathogenic stimuli, particularly viral and bacterial infections, may provoke an intense response and, ultimately, severe lung pathology in the rheumatoid patient. □

The Coronary Muse

By Watson Kirkconnell

6. The Mummies

In mighty Cairo, in the State Museum,
Stretched out in solemn halls for all to see 'em,
And bandaged tight, except for shrivelled faces,
A hundred mummies lay in mummy-cases.
Some forty years ago I saw them lie,
But could not fathom how they came to die.
Why were they swathed with such cold calculation?
Why had their eyes that look of desperation?
But now at last, when I have shared their woe,
I sense their secret from the long ago.
These were the coronary lads who lay
Inert on white ward cots in Pharaoh's day.
Beside each victim stood an anxious nurse:
"Don't stir a finger, or you'll soon be worse!
We wash your face and hands, your toes and teeth;
We turn you over when you're sore beneath."
And there were rebel patients, past all doubt,
Who said bad words and threw their arms about,
Till honest indignation flared at last
Among the sisters of the nursing caste.
"Girl Guides of Egypt, rally to our aid!
Get us a mile of roller bandage made!
And for our purpose you may bring us too
A hundred gallon tins of liquid glue!"
I see the sequel, as the sticky hands
Hem in the kicking feet, the flailing hands,
Till each man is encased from heel to head -
The nurse triumphant and the patient dead.
Partners in heart attacks, from this take warning,
Obey your nurses without oaths or scorning.
The coronary program may be tough,
But keep your tempers while the going's rough,
Lest wrapped in bandages from toes to face
You greet the future from a mummy-case. □

Personal Interest Notes

Personal Interest Notes

Like Oliver Twist we want to say "Please I want some more", - not gruel but the makings of the hodge podge of personal news items from all over the province which make up this page of the Bulletin. If, like Oliver, we should "come to be hung" for mistakenly reporting the activities of D.V.S.es, D.D.S.es and Ll.D's for M.D.'s, then its all in a good cause if correct activities are reported by **those whose duty it is to supply the correct account.**

ANTIGONISH-GUYSBOROUGH MEDICAL SOCIETY

Dr. and Mrs. Stanislaus Donigiewicz visited friends and relatives in Peterborough, Ontario recently. Dr. Donigiewicz attended the meeting of the American Anaesthetist Association in Boston before returning to Antigonish.

Dr. J. A. MacCormick, Antigonish has been appointed chairman of the Board of Health by the Antigonish Town Council for 1966.

Dr. Henry J. Bland of the Canso Medical Centre was sworn into office as Mayor of Canso at the organizational meeting of the new town council.

CAPE BRETON MEDICAL SOCIETY

1. **Doctor Andrew Russell Watson** is the radiologist at the New Waterford Consolidated Hospital. He was born in Sian, China. Following receipt of his M.D., he practised for many years in Africa and also has had military practice. He studied radiology in Glasgow and received his D.M.R.D. in London. He was senior consultant for the Northern Rhodesian Government Hospital of Lusaka, following which he came to Canada and had been in private practice before coming to New Waterford. We are pleased to have Dr. Watson join us.
2. **Doctor Allan Robert Ellecker** has been in this area for the past year or so and has now joined the Departments of Anaesthesia at both the hospitals in the Sydney area. He is doing full time anaesthesia. In October Doctor and Mrs. Ellecker welcomed a new baby boy to their home.
3. **Doctor G. S. Marsh** has now returned to Sydney and has opened an office in the new Medical Arts Building, specializing in ear, nose and throat. He has taken his specialty training in Detroit.
4. **Dr. Dan Nathanson,** a native of Sydney, who moved to New Waterford eleven years ago to establish a medical practice broke several precedents when, early in December he was elected Mayor of New Waterford. He doubled the total of votes polled for Mr. J. P. MacNeil, the former mayor. He became the first member of the Jewish faith to win the chief magistrate's post, and, besides being a very young mayor, 38 years old, he upset a local tradition of miner mayors which has been the rule for the last 40 years.

The Meritorious Service Medal, the highest award given by the Royal Canadian Legion was presented to **Dr. W. W. Patton** at an impressive banquet held at Glace Bay in November, sponsored by Branch 3 of the Legion in honor of Dr. Patton. The award which was presented by Zone Commander Angus MacDonald was in recognition of the vast service Dr. Patton has given the Legion and war veterans.

Service Clubs have been "spoken to" on various subjects by medical men lately. **Dr. Donald MacKenzie** gave a talk on Genetics at the Kinsmen Club, and **Dr. Charles Brennan,** who has been conducting a campaign on sex education in industrial Cape Breton, especially in Roman Catholic Schools, and has already addressed more than 2000 pupils, made a strong plea before the Rotary Club that sex education be incorporated in the curriculum of all schools in Cape Breton.

Nearly $2,700 has been turned over to the operating fund of the Baddeck Library by the Baddeck Men's Bridge Club in its 20 years of existence. This money has come from the 50 cents a week which each member has contributed. The first meeting was held at the home of Dr. C. L. MacMillan, and for its anniversary the Club met at the Library, where a birthday cake was cut by Dr. MacMillan, and a book by Farley Mowat was presented to him on behalf of the Library Board, by the president of the Board, Miss Nancy MacDermid.

COLCHESTER-EAST HANTS MEDICAL SOCIETY

Dr. J. T. Snow, Kennetcook was the guest speaker at the anniversary meeting of the West Gore Women's Institute held in January. The programme was under the direction of **Dr. Eliza P. Brison,** convener of health and welfare. Dr. Snow stressed the loss to a community when the wisdom and maturity of its elder members were not cherished and utilized.

Dr. Colin Stewart was elected Mayor of Stewiacke by acclamation at the recent election. He succeeded **Dr. H. B. Havey**, to whom reference was made in last month's Bulletin. To quote from the lead editorial in the Chronicle-Herald of November 23rd, 1965: "In spite of ill health he has continued as mayor to the present, combining the wisdom of long experience with such a courage as can only be an inspiration to those who know him ****Through depression and prosperity, through peace and war, Dr. Havey has provided Stewiacke with distinguished leadership and Nova Scotia with a remarkable example.

Cumberland Medical Society

Lately arrived from Britain is **G. A. Lawrence, M.D.**, a surgeon who has settled in Amherst. For the last five years he has worked at the United Norwich Hospitals, Norfolk, prior to that he practised surgery at various hospitals, including Guy's and the Brompton Chest Hospital. Born in Nottingham England, he did his medical training at Guy's, obtained his M.B., B.S. at London University, and in 1950, gained his L.R.C.P. and M.R.C.S. He is also a Fellow of the Royal College of Surgeons, England and Edinburgh.

Halifax Medical Society

Four Nova Scotian candidates have obtained fellowships with the Royal College of Physicians and Surgeons of Canada and were admitted to the College at the annual convocation in Montreal on Jan. 21. The five doctors all from the Halifax-Dartmouth area include: **Dr. Brian Chandler, Dr. Vincent Ing, and Dr. Samuel York,** Medicine, and **Dr. Donald Morris,** General Surgery.

Friends of **Dr. James Baker,** Wing Commander, formerly attached to the Canadian Forces Hospital, Halifax and later practising in Middleton before moving to HMCS Naden, Esquimalt in June, will learn with regret of the serious motor car accident in which he and his family were involved on December 22nd on their way to spend Christmas in San Francisco. The accident occurred at Medford, Oregon when the car went out of control on an ice patch. His oldest son, a student at Acadia was spending Christmas in Middleton, N. S. with his grandmother. Dr. and Mrs. Baker and Jo.Marie were slightly injured and were taken to hospital. Both Suzanne and Christopher were more critically injured. We hope that the month has brought complete recovery to all.

Dr. Samuel J. Shane, Associate Professor of Medicine, has been elected to the Council of the Canadian Cardiovascular Society for a five year term.

Dr. Shane, with Dr. Ian Rusted of St. John's, Newfoundland will be the Society Council's representatives in the Atlantic provinces.

Dr. S. Clair MacLeod, a graduate of Dalhousie, has returned from Australia to take up his post in the Department of Obstetrics and Gynaecology. Dr. MacLeod spent a year working in endocrinology on a McLaughlin Fellowship.

Perhaps the report of the retirement of **Dr. J. Fabian Bates,** Canada Pensions Commissioner since 1949 should come under Cape Breton Notes, for he was born in Sydney. However not even Cape Breton could contain him. As "Nova Scotian extraordinaire", - to quote Linden MacIntire of the Ottawa Bureau, "Fabie Bates", as he was known to the sport fans of more than a generation ago, has had a varied career. Before and during his college days, both at St. F.X. and at Dalhousie, no team was complete without him. The First World War sent him overseas, but gassing did not prevent him from joining an expeditionary force to northern Russia. Practice at Glace Bay and work for T.B. prevention occupied him between wars after graduation from Dalhousie. The second World War saw him again overseas as chief surgeon at No. 7 General Hospital, England. He returned to Camp Hill Hospital, Halifax, and to serve as Head at the Point Edward DVA hospital, Sydney. Then he went to Ottawa in 1949. Now he will be welcomed "home" by those who remember him as "a great old soldier, one of the best athletes the province has weaned and 'one of the best darn doctors Glace Bay has had in many a year' ".

Western Nova Scotia Medical Society

At the annual meeting of the Western Nova Scotia Medical Society held in December, at which **Dr. V. K. Rideout** was elected president and **Dr. Margaret Churchill,** Secretary, a letter was read from Mr. D. E. Brackenbury Marine Superintendent for Ridson Beazley, Ltd. It concerned the Southampton based salvage vessel, "Droxford" which came into Yarmouth a few times this year. The letter was addressed to the Chief of Defence Staff, Ottawa and reports in detail the heroic service rendered by Air-Sea Rescue Service recently to seamen injured on the "Droxford" during heavy storms. To quote only a small portion, "In my opinion the service given by these two doctors (**Dr. J. T. Balmanno** and **Dr. M. W. O'Brien**), was far beyond anything which one could normally or reasonably expect and reflects the highest ideals of the Medical Profession as far as **Dr. O'Brien** is concerned of personal courage as well. . . . .I assure you sir, this combined effort could not have been surpassed anywhere in the world and we are very grateful".

The whole letter reads like a bit of Conrad and our admiration for our colleagues is unstinted.

BIRTHDAY CONGRATULATIONS to **Dr. S. W. Williamson,** Nova Scotia's oldest practising physician who celebrated his 97th birthday in Yarmouth on January 13th. "This remarkable man of medicine who witnessed the transformation of the horse and buggy days and no hospital into a fast-moving jet age with a most modern hospital, not only practises his profession but takes a keen interest in medical matters generally and often attends the annual reunion of Dalhousie University Medical Alumni".

To **Dr.** and **Mrs. Robert Belliveau,** Meteghan, a son, on November 29th, 1965.

To **Dr.** and **Mrs. Robert L. Brown,** (née Jean Bishop), a daughter, Janet Katherine, at the Halifax Infirmary, on January 16th, 1966.

To **Dr.** and **Mrs. R. Phillip Carter, Jr.,** (née Sandra Smith), DeKalb, Illinois, a daughter, Andrea Rose, on December 27th, 1965.

To **Dr.** and **Mrs. Badi Haq,** (née Claudette Roux), a daughter, Gennifer at the Grace Maternity Hospital, on January 9th, 1966.

To **Dr.** and **Mrs. Fraser Macdonald,** (née Norma Wamback), a son, Edward Norman, at the Grace Maternity Hospital, Halifax, on December 23rd, 1965.

To **Dr.** and **Mrs. Elmer MacKenzie,** (née Lois Anderson), a son, Peter Anderson at Twin Oaks Memorial Hospital, Musquodoboit Harbour, on January 6th, 1966.

To **Dr.** and **Mrs. Laurie McNeill,** (née Gillian Giddy), a son at Victoria Public Hospital, Fredericton, N. B., on January 12th, 1966.

To **Dr.** and **Mrs. Roland Saxon,** (née Joan Inglis, RN.), a son at the Grace Maternity Hospital, on December 15th, 1965.

Dr. John D. Dinsmore, a veteran general practitioner from Port Clyde died in the Yarmouth Hospital recently, several days after suffering a stroke. He was in his late 70's. Dr. Dinsmore, a native of Port Clyde, Shelburne Co., practised in Honolulu for several years before returning to his native village.

A committal service was held on Nov. 19 for **Dr. Loren Gruber,** at the Knox Cemetery at Wallace Bridge, Cumberland county. He is survived by one brother, Dr. Maurice Gruber, Sac City, Iowa, two daughters and a sister. □