# THE NOVA SCOTIA MEDICAL BULLETIN

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# Next Year is Centennial Year

After the celebrations of the Centennial of Canadian Confederation have passed away into memory, when the flags have gone, and the bands no longer play, what then? When the magic lure of Expo 67 has vanished under the demolition hammer, what will remain to excite the appetite? While many canadians may be forgiven for feeling a little hung over and jaded in 1968, few may know that Dalhousie University is in the fortunate position of being able to prescribe the cure, and is, indeed, setting about it in a manner that will make the welkin ring.

The celebrations marking the hundredth Anniversary of the founding of Dalhousie Medical school will occupy three days that have been selected in September 1968, and a committee, under the able chairmanship of Dr. C. L. Gosse, has been hard at work for many months evolving a programme that will be worthy of the occasion.

As the programme takes shape it is evident that the committee has succeeded in its objectives of making this event an occasion which will transcend provincial and national boundaries, and focus the attention of the world upon Dalhousie University. Not only will it utilise the ultra-modern facilities of the Sir Charles Tupper Medical Building to the full, but it will gather under that roof an unparalleled collection of experts in the theme areas of the programme including many Nobel prize winners. Furthermore, these themes will be areas of rapidly expanding medical knowledge in which the experts themselves will rarely have had such an opportunity for discussion of mutual problems, so that not only will there emerge a concrete statement of today's knowledge in these areas, but also there will be a crystallization of thought on the trends for future research and development of the subject. Because of the importance of the conclusSons which will be reached during this three day Centennial Programme, the proceedings will be edited and published in a suitable form that will make it available to all Dalhousie Alumni, and to doctors and University Libraries throughout the world.

Few subjects could have aroused more interest, and more controversy, in recent years than organ transplant, yet the progress in this field is infinitesimal compared to the possibilities of future development. For years, genetics has remained a closed book to many, but recent advances in this field have brought a tremendous unfolding of knowledge, and with it the possibility of cracking the genetic "code" of many common disorders, bringing new hope for dramatic advances in treatment. In an era of " agonising reappraisals" the subject of Medical Education and its relation to the practice of the future stands out through its need for reassessment of present attitudes and new aids. These are the three topics chosen for the Centennial programme, through which Dalhousie University will celebrate its past and point the way for itself and others for the future.

A detailed discussion of the programme is not possible here, but to illustrate the challenging format developed for this conference, the day devoted to discussion of organ transplantation will be briefly sketched in. Following the Keynote Address by Sir Peter Medawar, members of the audience will adjourn to the panel of their choice. There will be six simultaneous panels, each examining a particular aspect of the problem. While one panel examines the ethical and legal aspects of organ transplantation, a second will look into the evolutionary and developmental bases of immunity reactivity, and a third will pursue the question of immune recognition and transplant tolerance. At the same time, other panels will discuss donor selection, the mechanisms of graft rejection and the surgical aspects of organ transplant. Each panel will be chaired by an internationally renowned expert in the particular aspect under discussion, including, among others, such distinguished physicians as Dr. Francis D. Moore, of The Peter Bent Brigham Hospital and Harvard University, Boston, U. S. A.; Dr. N A. Mitchison, of the Division of Experimental Biology, National Institute for Medical Research, London, England, and Dr. Jean Dausset, of the Laboratoire d'Immuno-hématologie, Institut de Recherches sur les Maladies du Sang, Université de Paris, France.

Following these separate panels, the audience will recombine, while the chairmen of each of the six panels will unite to participate with the audience in a round table discussion summarising the conclusions of each panel.

In addition to inviting its own Alumni, Dalhousie University will be issuing invitations to many Universities, medical centres and organisations throughout the world to share in this exciting Centennial Programme: the new facilities of the Sir Charles Tupper Medical Building will accomodate an attendance of six hundred participants, but those unlucky enough to be unable to find a place will be able to watch the proceedings through its closed circuit television facilities.

Lest the high quality of the academic programme should deter some, it should be emphasised that there will be something of interest to everyone in each of the days discussions, and a programme of social events, dinners, and class reunions is being planned to provide relaxation and good company during the three days of celebration.

This, then, is why Centennial is next year, and why Dalhousie University will become the focus of world attention during the fall of 1968.

The Theme is the future; the Scene, the Sir Charles Tupper Medical Building, and the dates September 11th, 12th, and 13th, 1968. Mark them in your calender now. □

I. E. P.

## FORTY YEARS AGO

From The Nova Scotia Medical Bulletin
October 1927

When a discovery that seems to possess therapeutic promise is made in the laboratory, it is the practice of some manufacturers to subject it to clinical trial. Certain physicians who have unusual opportunities for making clinical observations are asked to try out and report on the efficiency of the new remedy. Should the preponderance of clinical evidence prove favorable, the preparation is carefully standardized, protected as far as possible from deterioration, and offered to the profession generally. New medicinal preparations offered by firms which adopt this system of making a clinical assay are not, therefore, novel, in the strict sense, but have already passed safely through the first degree in their initiation into the family of official remedies. Reluctance on the part of many members of the profession to be the first to adopt or encourage innovations has, possibly, been unduly featured in the past as a commendable conservatism, but it seems questionable whether it will continue to be so regarded as scientific accuracy more and more replaces guesswork in the diagnosis and treatment of disease.

Scientific methods combined with systematic business principles dominate all branches of industry to a more marked degree with each succeeding year. The Curies discover radium, and organized business offers it to the world; Banting isolates insulin, and pharmaceutical manufacturers prepare it for the profession chemists invent tetraiodedephenylphthalein and Roentgen discovers the X-rays, and by means of these, supplied by commercial houses, the gall-bladder becomes visible; and this is the history of all material contributions that are now being made to the healing art.

The practice of medicine is no longer an isolated profession. In the light of modern thought it may rather be conceived as one of the great scientific developments of the past half century. Like all other branches of human endeavor, it has been profoundly modified by the general advance in knowledge, and the rising generation of physicians and surgeons are regarding the pharmaceutical manufacturer more and more as a sort of central clearing house wherein therapeutic agents are analyzed and sifted before they are recommended for general use by the medical profession. □

# Thioridazine In Depression

A. G. KHAKEE, MB, BS

*Provincial Hospital*

*Lancaster, N. B.*

The discovery of the phenothiazines and their introduction into psychiatry has revolutionized the treatment of the psychoses. At the present time at least ten phenothiazines are in clinical use. The more widely used derivatives are chlorpromazine and trifluprom azine (with a dimethyl amino side-chain), trifluoperazine and perphenazine (with a piperazine side-chain) and thioridazine (with a piperidyl side-chain).

The mode of action of the phenothiazines is not completely understood. They depress central and sympathetic nervous system activity and in addition, depending on the side-chain, possess varying antihistaminic, anticholinergic, antispasmodic and antiemetic effects. Their exact site of action has not been established, but it is believed that they act on the reticular formation and sympathetic centers in the hypothalamus in varying degrees.

Clinically, in therapeutic doses, they induce emotional calmness and mental relaxation, are effective in controlling the symptoms of acutely and chronically disturbed psychotic patients, have almost no tendency to produce drug-dependence or addiction[2] and have well recognized side effects which vary with the particular phenothiazine being used.

In a review article of 178 clinical publications, Anderson et al[1] summarized the side effects associated with phenothiazines. A higher incidence of extrapyramidal phenomena was noted during the administration of phenothiazines with a piperazine side-chain than with any other side-chain. Certain phenothiazines, particularly those with dimethylamino and piperazine side-chains, induced or aggravated depression.

A review of European,[6] Canadian[4] and American[2,5] literature has indicated that one of the phenothiazines, thioridazine (Mellaril), counteracts depression. Recent publications[2,5] have queried the arbitrary division between tranquilizers (particularly thioridazine) and anti-depressants (especially imipramine). Chlorpromazine and thioridazine are very similar structurally to imipramine and amitriptyline, but this cannot presuppose a similar clinical action.

The purpose of this study was to investigate the previously reported beneficial effects of thioridazine (Mellaril) in depressive symptomatology associated with and without the use of anti-depressants.

## Methods

Thirty female patients were employed in the study. Their average age was 34 years (range - 18 to 63 years). Three types of depression were reported in this group of patients: –

1. Endogenous depression as part of a psychosis
   a. manic-depressive in a depressed phase
   b. involutional depressive reactions
2. Depressive tendencies in schizophrenics
3. Neurotic depressive reactions (Table I)

**TABLE I**

DIAGNOSES IN A GROUP OF 30 DEPRESSED PATIENTS

| Depressive Condition | Number of Patients |
|---|---|
| 1. Endogenous depression – a) manic depressive – depressed or mixed (6) b) involutional (8) | 14 |
| 2. Schizophrenics with depressive symptomatology | 11 |
| 3. Neurotic depressive reaction – anxiety, obsessive, phobic, depressive | 5 |
| **Total** | 30 |

The study was organized in the admission service of the hospital and the patients involved were in the acute phase of their illness. Psychiatric evaluation was performed by a psychiatrist and by nurses in charge of the ward. (Table II) All patients received thioridazine ranging from 100 mg. to 800 mg. per day. In addition to thioridazine, ten patients with endogenous depression (4 manic-depressive, 6 involutional) received an anti-depressant.

Improvement was assessed subjectively from patients' reports and objectively by an evaluation of changes in mood, depressive ideation, facies, retardation, agitation (psychic and motor) and participation in group activity on the ward.

## Results

The results of thioridazine treatment are shown in Table II. Only three patients failed to show any improvement, one depressed schizophrenic and two neurotic depressives. Relief of agitation usually ocurred in the first week on the drug but three to

**TABLE II**

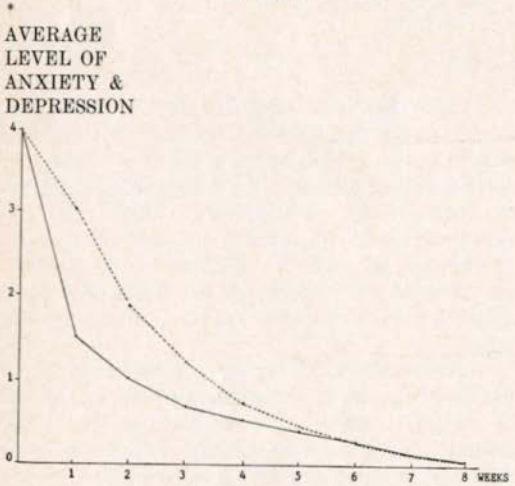
RESULTS OF THIORIDAZINE TREATMENT IN 30 DEPRESSED PATIENTS

| Depressive Condition | Results: Improvement | | | | |
|---|---|---|---|---|---|
| | Marked | Moderate | Slight | None | Total |
| 1. Endogenous depression | | | | | |
| a) manic depressive – depressed or mixed | | 6 | | | |
| b) involutional | 8 | | | | 14 |
| 2. Schizophrenics with depressive symptomatology | 5 | 4 | 1 | 1 | 11 |
| 3. Neurotic depressive reaction anxiety, obsessive, phobic, depressive | 1 | 1 | 1 | 2 | 5 |
| **Total** | 14 | 11 | 2 | 3 | 30 |

four weeks of treatment were required before depressive symptoms regressed (Fig. 1). The average duration of hospitalization was six to eight weeks.

Nine of the twenty patients were suffering from depression which was unmasked when their psychosis was controlled by phenothiazines other than thioridazine. Thioridazine was substituted in these patients with remarkable results. The following two case histories are illustrative.

**FIGURE 1**




DURATION OF REDUCTION OF DEPRESSIVE SYMPTOMATOLOGY

———— ANXIETY ..... DEPRESSION

* 4 – symptom severe 2 – symptom moderate

3 – symptom marked 1 – symptom mild

0 – no symptom

**Case 1:** A. T., a schizophrenic female patient, was admitted to hospital because of paranoid ideation, self-accusatory delusions and hallucinations. Treatment with chlorpromazine 300 mg. daily for a year improved these symptoms. However, she continued to show mild listlessness, mild psychotic retardation, apathy and overt depressed feelings. In view of these symptoms, thioridazine 300 mg. daily was substituted for chlorpromazine. Improvement was soon evident in her social attitude and participation in ward activities and was supported by the patient's own statement that she felt better. After two months on thioridazine, the dose was gradually reduced to 150 mg. daily. She was discharged on this dose of thioridazine.

**Case 2:** H. R., a 34-year-old female, was admitted to hospital because of violent outbursts at home. In hospital she displayed marked paranoid delusions and hostility. Chlorpromazine, 50 mg. t.i.d. intramuscularly was administered for three days following admission and thereafter chlorpromazine was given orally, 900 mg. daily. Her overt psychomotor state regressed. However, the patient developed mild parkinsonian signs and became apathetic, listless and depressed. After 2 months, thioridazine 300 mg. daily was substituted for chlorpromazine and both the parkinsonian and depressive phenomena improved.

**Discussion**

This study confirms the findings of other investigators[2,4,5] that thioridazine is useful in the treatment of depression. Schnetzler[6] compares the state of "well-being" of the patient receiving thioridazine to "the feelings of any normal person who is without internal tensions and who is not bothered with unpleasant side-effects such as those encountered with other tranquilizers." However, a more specific antidepressant effect for thioridazine is proposed by Lehmann,[4] Overall[5] and Cohen.[2] Lehmann[4] found thioridazine effective in controlling "phenothiazine-induced depression" in six out of nine schizophrenics. These patients had previously received a different phenothiazine and "had presented a depressive mood", hence the term phenothiazine-induced depression. Anderson[1] et al, in their review article deduce that phenothiazines with dimethyl amino and piperazine side-chains induce or aggravate depression. This is not the view taken by Cohen[2] who believes that the administration of certain phenothiazines in cases where depression is overshadowed by a more overt psychotic state may cause regression of the psychotic symptoms and at the same time unmask the underlying depression which is not controlled by the regime. Eight patients in our study fell into this category. Thioridazine was effective in alleviating this depression and should prove valuable in the treatment of schizophrenics in whom depression is an integral factor.

**(continued on page 202)**

# Sigmoidoscopy
# The Neglected Aid in Cancer Detection

JAMES H. MACLEOD, BSC, MD, CM, FACS, CRCS

*Ferguson Clinic, Grand Rapids, Michigan**

**"Sigmoidoscopy Can Lead to the Saving of More Lives Than Any Other Step in the Annual Check Up"** This statement in a current publication of the American Cancer Society[1] isjustified by these facts:

1. Cancer of the colon and rectum accounts for 15% of all cancer deaths.[1,2]

2. Sixty-five to 75% of cancers of the colon and rectum occur in the distal 25 cm. of the alimentary tract, ie. within range of the sigmoidoscope.[1]

3. Nearly 30% of all fatal cancers occur within range of the sigmoidoscope.[1]

4. Controlled studies have shown that patients subjected to periodic routine sigmoidoscopic examinations do, in fact, have a significantly lesser mortality from cancer of the colon and rectum than does the general population.[2]

## The Natural History of Carcinoma of the Rectum and Colon

Cancer of the colon and rectum is the second greatest cancer killer, being second only to cancer of the lung in the male and to cancer of the breast in the female.[1] In contrast to these cancers, it is slow growing; it is present a long time before symptoms develop[2]; its behaviour is relatively predictable, and the prognosis is directly related to the length of time the cancer has been present.[2] The overall survival rate with this disease is 30% to 35%. However, of patients with cancers *confined to the intestinal wall*, 60% to 65% are five year survivors, and when correction is made for operative mortality and the calculated normal mortality rate in this age group, nearly 90% are five year survivors.[2] But most patients do not have cancers confined to the intestinal wall when first seen and once the tumor has spread outside the wall of the intestine, currently employed operative procedures more frequently than not fail to encompass all of the cancer. In other words, only *one-third of patients with cancer of the colon and rectum survive, but two-thirds would survive with earlier diagnosis.* The average delay from onset of symptoms to institution of treatment because of patient delay or physician delay, is quoted as six months.

## The Delay in Diagnosis

*Lessening of the delay* from onset of the symptoms until time of treatment would appear to have a direct effect on prognosis; detection of the cancer *before the onset of symptoms* appears to effect a dramatic increase in survival rate.[2]

Approximately 76,000 new cases of colon and rectal cancer will be diagnosed in the U.S. this year and approximately 43,000 will die of cancer of the colon and rectum in this same year.[1] The figures for Canada are proportional[4], as are those of Nova Scotia, although the mortality rate in Nova Scotia appears to be somewhat higher. There were 234 deaths reported in Nova Scotia in 1966 due to carcinoma of the colon and rectum.[5] Many of these could have been detected by the sigmoidoscope while still curable.

## Sigmoidoscopy as a Routine Cancer Detection Test

Even those individuals who routinely submit themselves to the most comprehensive diagnostic procedures for the detection of cancer rarely undergo sigmoidoscopy. Many other less productive procedures are performed as part of a routine examination, e.g. otoscopic examination. Cytologic examination in females is routinely performed by many physicians and should be by all, since this has resulted in a 40% to 50% reduction in deaths due to uterine cancer in the past 25 years. However, the number of anticipated deaths due to carcinoma of the colon and rectum in women will be two to three times as many as those due to uterine cancer and about 70% of these lesions will be within range of the sigmoidoscope.[1] While digital rectal examination is indeed a valuable diagnostic procedure, only 12% of colon and rectal cancers occur within reach of the examining finger.[2] It should not be necessary to point out that sigmoidoscopy should be performed on any patient with complaints referable to the intestinal tract, as well as being part of a routine physical examination. However, a definite percentage of patients with undiagnosed intestinal cancer continue to undergo medical or surgical treatment for hemorrhoids; many also undergo prolonged medical treatment for anemia of undedetermined origin.

*Present address: Halifax, Nova Scotia

**Sigmoidoscopy is Not a Procedure That Must Be Performed Only by a Specialist:** it is not difficult or time consuming, nor does it require a great deal of equipment or preparation. All that is necessary is a standard 25 cm. sigmoidoscope with an electrical source, a suction unit, disposable enemas, and an accessible toilet. The standard flat examining table is quite adequate. The technique is simple and is not dangerous if reasonable care is taken not to advance the sigmoidscope without complete visualization of the bowel lumen at all times and if force is not used in advancing the instrument.

**Conclusions:**

Cancer of the distal 25 cm. of the colon and rectum is a curable disease. It is urged that sigmoidoscopy be performed in any routine physical examination as well as in any patient with rectal complaints. This can result in a dramatic increase in the survival rate. *The physician who does not include sigmoidoscopy as part of a physical examination is performing an incomplete examination.* □

**References**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(Thioridazine - continued from page 200)

Thioridazine alone was of value in the four depressive psychotics with motor retardation in our study, thus confirming the findings of Overall et al[5] and Cohen.[2] Overall and his co-workers[5] found no statistically significant differences between the therapeutic effectiveness of imipramine and thioridazine in a study of 77 depressive patients. In a rigorous, well-designed trial comparing imipramine and thioridazine Cohen[2] found that thioridazine exceeded imipramine "in anti-depressant qualities."

**Summary**

Thioridazine was found effective in the treatment of psychotic patients in whom depression was part of the symptom complex. □

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# Third Conjoint Scientific Assemble

## MARITIME PROVINCES CHAPTERS COLLEGE OF FAMILY PHYSICIANS OF CANADA

*Charlottetown, P. E. I.* *October 20th - 21st, 1967*

Charlottetown's Confederation Center will be the location for the third Conjoint Scientific Assembly of the three Maritime Provinces Chapters of the College of Family Physicians of Canada on October 20th and 21st next. This Assembly has now become an established annual event in the continuing postgraduate training of the Family Doctors of the Maritimes and is increasing in size and scope annually.

The scientific programme is planned in co-operation with the postgraduate division of the Faculty of Medicine of Dalhousie University and the Social programme in co-operation with the Prince Edward Island Medical Society and local P.E.I. members of the College of Family Physicians of Canada.

Study periods will include sessions on Neonatology, one of medicine's newest specialties - the study of problems concerning the first month of life. These will be lead by Dr. R. H. Usher, a Neonatologist on the staff of McGill University, Montreal and the Montreal Children's Hospital. Dr. Usher will also deliver the Mead-Johnson Modern Paedatrics Lecture for 1967, on the subject "The Respiratory Distress Syndrome of Prematurity".

Also attending will be Dr. Richard B. Goldbloom, recently appointed Professor of Paedatrics at Dalhousie University, Halifax, N.S., and Chief of Medicine at the Halifax Children's Hospital.

The P.E.I., N.B., and N.S. Provincial Chapters of the College of Family Physicians of Canada will hold semi annual business meetings during the Assembly, at which the National Executive of the College of Family Physicians will be represented by the President, Dr. W.E.H. Alport of Regina, Saskatchewan, and the Executive Director, Dr. D. I. Rice of Toronto, Ontario.

The Conference Chairman is Dr. W. R. Gillis of Moncton, New Brunswick. The Planning Committee also includes Dr. L. C. Steeves and Dr. Paul Cudmore of Halifax (Secretaries) Dr Kent and Ellis, Hunter River, P.E.I., Dr. John Gillis, Eldon, P.E.I. and Dr. Marven Clarke, Kensington, P.E.I. (Registration, Housing, Local Arrangements and Entertainment), Dr. H. A. MacMillan, Charlottetown, P.E.I. (Finance), Dr. J. D. Carson, Windsor, N.S. (Exhibitors), Dr. Norman Glen, Amherst, N.S. and Dr. Ralph Kennedy, Charlottetown P.E.I. (Publicity) and Dr. John Hamm, New Glasgow, N.S., Dr. T. E. Atkinson, Salisbury, N.B. Dr. Waldo Hirtle, Sackville, N.B. and Dr. Phillip Jardine, Musquodoboit Harbour, N.S. □

# TRANSACTIONS

## Second Meeting of Council and 113th Annual Meeting
## Medical Society of Nova Scotia

Lord Nelson Hotel, Halifax – November 25th & 26th, 1966

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### 113th Annual Meeting - INDEX

# Second Meeting of Council

## INTRODUCTORY NOTES

The second meeting of the Council of the Society and the 113th Annual Meeting was held in the Lord Nelson Hotel, Halifax.

Invited guests were Dr. Normand Belliveau, President-Elect, Canadian Medical Association and Mrs. Belliveau; Hon. R. A. Donahoe, Minister of Public Health and Mrs. Donahoe; Mr. R. McD. Black, Q.C., Chairman, Medical Care Insurance Advisory Commission and Mrs. Black; Dr. D. M. Aitken, Assistant Secretary, Canadian Medical Association and Mrs. Aitken; Dr. L. P. Chiasson, Chairman, Nova Scotia Hospital Association; Mr. M. Macdonald, Executive Secretary, Nova Scotia Hospital Association; Mr. R. E. J. Ricketts, Nova Scotia Tuberculosis Association; Mr. J. A. MacGlashen, Nova Scotia Rehabilitation Council; Miss J. E. Hudson, Arthritis & Rheumatism Society; Col. F. R. Cullen, Regional Surgeon, Atlantic Medical Region; J. E. Merritt, D.D.S., President, Nova Scotia Dental Association; Dr. F. L. Whitehead, Secretary, New Brunswick Medical Society; Dr. J. R. Boulay, President, New Brunswick Medical Society; Dr. A. R. Mercer, President, Newfoundland Medical Society; Dr. W. D. Parsons, Secretary, Newfoundland Medical Society; Dr. H. Allan MacMillan, Secretary P.E.I. Medical Society; Mr. S. P. Brannan, General Manager, Maritime Medical Care Inc.; Mr. W. R. Stevenson, President, Dalhousie Medical Students Society; Mr. W. J. MacInnes, Q.C., Legal Counsel, Medical Society of Nova Scotia; Mr. D. H. Waller, Executive Secretary, Medical Care Insurance Advisory Commission; Mr. S. S. Jacobson, Medical Care Insurance Advisory Commission; Mr. John H. Delaney, Medical Care Insurance Advisory Commission; Dr. T. W. Gorman, Medical Care Insurance Advisory Commission; Dr. J. C. Wickwire, Medical Care Insurance Advisory Commission.

The Council of the Society held three Sessions: –
Friday, November 25th 9.30 a.m. – 12.30 p.m.
Friday, November 25th 2.00 p.m. – .4.00 p.m.
Saturday, November 26th 9.00 a.m. – 12.30 p.m.

There were two Sessions of the 113th Annual Meeting: -
Friday, November 25th 4.00 p.m. - 5.00 p.m. when the Nominating Committee reported and the Officers for 1966-67 were elected.
Saturday, November 26th at 2.00 p.m. when the deliberations of Council, as the governing body of the Society, were reported to the general membership.

Other meetings held were : –
The Annual Meeting of the Executive Committee (1965-1966) on Thursday, November 24th. The Committee on Committees met on Friday, November 25th 8.00 a.m., and Saturday, November 26th 8.00 a.m.
The 1st Meeting of the incoming Executive Committee was held on Saturday afternoon, November 26th at which time the report of the Committee on Committees was considered and Chairmen of Committees and representatives from the Society to other organizations were appointed.
The Clinical Programme for the Annual Meeting was the 40th Annual Dalhousie Refresher Course, November 21st – November 24th inclusive. Joint Registration was available for the Meeting of Council, the Annual Meeting, and the Clinical Programme thus covering the period, November 21st to November 26th inclusive. 145 registered for the Clinical Programme.

115 had been designated as representatives to Council. 85% of that number registered. Attendance at Sessions of the Council ranged from 85 to 100.

Social events. Dr. N. J. Belliveau, President-Elect, C.M.A., spoke at the Luncheon Meeting on Friday.

A Programme for the Ladies had been arranged by Mrs. A. J. M. Griffiths and a committee.

The President's Reception Annual Banquet, and Annual Ball took place on Friday evening, November 25th.

Representatives of the Press were present on invitation at all Sessions of the Council and the Annual Meeting.

The President, Dr. A. J. M. Griffiths, Chaired the Sessions of Council, the Sessions of the Annual Meeting and presided at the Reception, Annual Banquet and Annual Ball.

The volume of Annual Reports from Chairmen of Standing Committees, Special Committees, and representatives to other organizations, had been distributed two weeks in advance to the members of Council. The reports were also available at the time of registration. Any member wishing to have a copy of these reports is invited to write to the office of the Society.

## FIRST SESSION OF COUNCIL*

**Friday, November 25th, 9.30 a.m.**

AC1—The President, Dr. A. J. M. Griffiths as Chairman of Council called the meeting to order at 10.00 a.m. 85 members of Council were present. He extended a particular welcome to the guests particularly Dr. N. J. Belliveau, President-Elect Canadian Medical Association, and Dr. D. M. Aitken, Assistant Secretary.

AC2—The Executive Secretary was asked to read the names of the members deceased between October 30th 1965 and October 31st 1966 as follows: -

Currie, W. A., M.D. September 9th, 1966
Belliveau, Pierre E., M.D., October 4th, 1966
Khatter, Thomas J., M.D., June 10th, 1966
Morrison, Clarence W., M.D., August 23rd, 1966
MacKenzie, Ian., M.B., October 17th, 1966
Nichols, Roberta B., M.D., October 29th, 1966
Smith, Ralph L., M.D., July 7th, 1966

The Chairman requested one minute of silence in tribute to the memory of these deceased members.

AC3—The Executive Secretary then read the names of 53 physicians who had applied for membership in the Society between November 10th 1965 and October 30th 1966.

On motion these physicians were approved as members of the Society.

AC4—The Transactions of the Sessions of Council 1965 and the Annual Meeting 1965, as printed in the March 1966 issue of The Nova Scotia Medical Bulletin were, on motion adopted.

AC5—The Chairman named Drs. Devereux, H. E. Christie and D. R. Campbell to be the Resolutions Committee for the meeting.

## REPORTS OF COMMITTEES & REPRESENTATIVES

AC6—**The Executive Committee:** (AR p. 1-2) Chairman, Dr. S. C. Robinson.

This report reviewed the activities during the year including those of the Physicians' Services Insurance Committee which had reported regularly to each Executive Committee Meeting; that there has been an extension of coverage and improved terms for several Welfare Groups under the agreement between the Department of Public Welfare and the Society; that improved contact had been developed with the Provincial Medical Board with progress towards better understanding; that the Committee on Legislation & Ethics had reported on some question regarding Chiropractors and that the 1st "Summer Meeting" at the Pines, Digby had been an outstanding success.

AC7—**Recommendations**

(a) That Chapter IX "Council" Article II (Composition of Council), para (a) (VIII) be amended by replacing the current wording with the words "members of the Society who are members of the General Council of the Canadian Medical Association".

It was also recommended that the Dean of Medicine, Dalhousie University be recognized as a member of Council.

(b) That Chapter XII (Committees), Article III (the Nominating Committee) (a) "Appointment of a Nominating Committee" be amended by adding a subsection to read "The President-Elect shall be a member of the Nominating Committee."

AC8—The Annual Meeting was informed that the Executive Committee on October 22nd 1966 had approved the application of the Dartmouth Medical Society for recognition as a Branch Society of The Medical Society of Nova Scotia.

Dr. S. C. Robinson moved, and Dr. F. G. Mack seconded that each of the foregoing recommendations be accepted. Motion CARRIED.

AC9—**Committee On Public Relations:** (AR p. 40) Chairman, Dr. I. E. Purkis.

Dr. Purkis moved that the body of his report and the summary be accepted for information. This was seconded by Dr. H. I. MacGregor and CARRIED.

AC10—Dr. Purkis then presented the **Recommendations** as follows: –

1. "That a campaign be mounted to give greater prominence to the Society's views on Highway Safety". Motion for adoption by Dr. Purkis, seconded by Dr. Maxwell and CARRIED.
2. Copies of the Society's Memoranda to the Planning Commission (Medical Care Insurance Advisory Commission) be available in the secretary's office for any member approached to speak before any audience on "Medicare". Moved for adoption by Dr. Maxwell, seconded by Dr. H. J. Devereux. CARRIED.

AC11—**Report of Representatives to C.M.A. Executive:** (AR p. 46-54). Dr. H. J. Devereux.

Dr. Devereux's lengthy report was detailed and comprehensive. Having reviewed the substance of the report Dr. Devereux moved that it be received for information. Dr. C. B. Stewart in seconding the motion stated that he wished to introduce a resolution after this motion had been disposed of. Before the motion was put to a vote Dr. Normand Belliveau, President-Elect, Canadian Medical Association, spoke on various items in the report. The motion to accept the report for information was CARRIED.

AC12—Dr. C. B. Stewart, stating that the Canadian Medical Association had offered a gift to Dalhousie University in the form of a Bronze Bust of Sir Charles Tupper which would be displayed in the Sir Charles Tupper Medical Building, proposed the following resolution:

**AC'66 No. 1:** –
Moved by Dr. C. B. Stewart.
Seconded by Dr. K. M. Grant.

> "That the Council of The Medical Society of Nova Scotia express its sincere thanks to the Canadian Medical Association for the generous gift to Dalhousie University of a Bronze Bust of Sir Charles Tupper for display in the Sir Charles Tupper Medical Building." CARRIED.

AC13—Dr. L. C. Steeves referred to paragraph AR145 re the site for the Headquarters of the Canadian Medical Association. Dr. N. J. Belliveau gave information on the subject. The following resolution was then presented: –

**AC'66 No. 2:**
Moved by Dr. L. C. Steeves.
Seconded by Dr. A. A. MacDonald

> "That The Medical Society of Nova Scotia favour a wide search for the most appropriate site for C.M.A. House with serious consideration being given to the National Capital." CARRIED.

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*AR — Annual Reports
AC — Annual Council
AM — Annual Meeting
AE — Annual Executive

**AC14—Finance Committee:** (AR p. 11-16) Honorary Treasurer, Dr. C. D. Vair.

The report presented a financial statement in the form of an itemized budget for 1966 and the actual expenditures to September 30th 1966; a statement of capital for the year ending December 1965; a statement of income and expenses for the year ending December 31st 1965 and a statement of investments to December 31st 1965. Dr. Vair forecast increased expenditures in 1967 on the basis of printing the Schedule of Fees; furnishing and preparing office space in the new Sir Charles Tupper Medical Building; increase salaries for the staff and increasing responsibilities and work by the Physicians' Services Insurance Committee including services from legal counsel.

**AC15**—Dr. Vair moved and Dr. Ian MacGregor seconded that the report be received for information. CARRIED.

**AC16—Recommendations.**

1. "That authority be granted for a special levy of $10 per member to meet expenses involved in the work of the Physicians' Services Insurance Committee.

The Annual Meeting of the Executive Committee had presented resolution AE'66 No. 4: –

Moved by Dr. G. McK. Saunders

Seconded by Dr. H. I. MacGregor

"That recommendation No. 1 of the Committee on Finance be changed to read 'that authority be granted for a special levy, if necessary, of up to $10 per member to meet expenses involved in the work of the P.S.I. Committee'." CARRIED.

It was moved by Dr. Vair and seconded by Dr. S. C. Robinson: –

"That recommendation No. 1, as amended by the Annual Meeting of the Executive Committee, be adopted." CARRIED.

2. "It is recommended that, in the future, travel for Executive members attending various Branch Society meetings and travel expenses for the Executive Secretary be in two separate accounts instead of the present combined account. Moved by Dr. Vair and seconded by Dr. H. I. MacGregor, "THAT recommendation No. 2 be accepted." CARRIED.

3. "It is recommended that the work and cost involved to the Society for various federal-provincial projects sponsored by the Society be studied in the hope that another agency could take over this task." Dr. Vair moved, and Dr. H. J. Devereux seconded the motion for adoption of the resolution. Considerable discussion ensued in which Dr. Steeves spoke against this recommendation as did Dr. Gorman and Dr. D. F. Smith. Discussion indicated advantages to the Society and the community for the Society to be involved in these projects. The motion for adoption of Recommendation No. 3 was DEFEATED.

4. "That the social registration fee at both the Annual Meeting and the Summer Meeting be $15." In moving adoption of this recommendation Dr. Vair explained that the social registration fee had been $10 but that the Executive had the authority to increase this up to $15 as indicated. He wished to have the endorsement of Council for the change recommended. The motion was seconded by Dr. R. B. Belliveau and CARRIED.

5. "That we explore the advisability of the fiscal year of the Medical Society ending in September rather than December." Dr. Vair, proposing a motion for adoption, stated that this change would make it possible to have the current fiscal Annual Report available at the Annual meeting in November of each year. Dr. Ian MacGregor seconded the motion for adoption which was CARRIED.

**AC17—Membership Committee:** (AR p. 26-27) Chairman, Dr. M. G. Tompkins.

Dr. Tompkins reported that the membership as of October 31st numbered 676 and that 8 members had not paid dues for 1965 or 1966. He reported that an intensive effort is being made to have all physicians receiving post-graduate training join the Society. The names of the 53 new members had been read by the Executive Secretary and on motion had been accepted as members of the Society. On motion the report of the Committee on Membership was accepted for information. There were no recommendations.

**AC18**—The Chairman declared 20 minutes recess for coffee and visiting the exhibitors.

**AC19**—On reconvening the 1st Session of Council 1966 resolution AC'66 No. 3 was introduced: –

**AC'66 No. 3:**

Moved by Dr. H. J. Devereux

Seconded by Dr. I. D. Maxwell

"That the reports of the Committees on By-Laws, Insurance and Archives be received for information." CARRIED.

**AC20—Special Committee On Office Space:** (AR p. 91) Chairman, Dr. C. L. Gosse.

Dr. Gosse reported that Dalhousie University had offered to the Society space of approximately 800 sq. feet on the 15th floor of the Sir Charles Tupper Medical Building."- - - as evidence of the warm and unique relationship that exists between the Dalhousie Medical School and the practising physicians of Nova Scotia". A general outline of the arrangements was presented. It is expected that the space will be available for occupancy about the end of August 1967.

**AC21**—A motion to accept this report for information was regularly moved, seconded and CARRIED.

**AC22**—During discussion of the report resolution AC'66 No. 4 was presented: –

**AC'66 No. 4:**

Moved by Dr. C. L. Gosse

Seconded by Dr. C. E. Kinley

"That The Medical Society of Nova Scotia record its appreciation of the generosity of Dalhousie University Faculty of Medicine and C. B. Stewart, M.D., in particular in providing space for the Society offices in the Sir Charles Tupper Medical Building." CARRIED.

**AC23—Committee On Maternal & Perinatal Health:** (AR p. 72-74) Chairman. Dr. D. F. Smith.

Having presented his report Dr. Smith moved, seconded by Dr. Greening that this report be received for information. CARRIED. The two recommendations were considered separately.

**AC24—Recommendations.**

1. "We would like the permission of the Society to contact the Medical Record Librarians of each hospital where obstetrical care is given and request continuing yearly reports of perinatal deaths by weight groups." Discussion clarified the intent of "yearly reports of perinatal deaths" as being the case numbers only. On motion of Dr. Smith, seconded by Dr. Maxwell recommendation No. 1 was ADOPTED.

2. "We would like to set up a system of yearly review of all perinatal deaths in the province. Several possible systems to accomplish this are available.

(a) Each Branch Society to set up a "Regional Perinatal Mortality Committee" to extract information from the charts of each perinatal death and to send such information to the "Central Perinatal Mortality Committee" for analysis and constructive comments.

(b) Each hospital to send the charts of all perinatal deaths to the central committee for analysis and comment.

(c) Each doctor having a perinatal death to fill out an information sheet to become part of the patient's hospital record and a copy to be sent to the central committee for analysis and comment."

**AC25**—Discussion on points of clarification of recommendation No. 2 and its subdivision resulted in the suggestion that the Nova Scotia Hospital Association be approached to assist the committee in implementing these recommendations. On motion recommendation No. 2 was approved. Arising from discussion resolution AC'66 No. 5 was presented: –

**Ac'66 No. 5:**
Moved by Dr. J. S. Robertson
Seconded by Dr. C. B. Stewart
"That the Hospital Insurance Commission be requested to advise hospitals that assistâce should be given to mothers of babies born in Nova Scotia hospitals in filling out the required Registration of Birth." CARRIED.

**AC26—Editorial Board Of Nova Scotia Medical Bulletin:** (AR p. 9-10) Chairman, Dr. J. F. Filbee.

Dr. Filbee reviewed the report stating that the new format of The Nova Scotia Medical Bulletin had proved to be satisfactory, that production of the Bulletin is becoming more complex, that there had been a change in the method of accounting for the Bulletin which showed a deficit for the current year whereas on the basis of the previous method of accounting there would have been a small surplus. On motion by Dr. Filbee, seconded by Dr. Devereux the report was received for information.

The two recommendations were presented: –

**AC27—Recommendations.**

1. "There is a continued need for articles for publication, especially news from all members and from each Branch Society for the Personal Interest Notes.
2. The Editorial Board recommends a suitable presentation to Mr. C. K. Goodman (of the Ontario Medical Review) in appreciation of the services he has rendered the Bulletin."

**AC28**—On motion each of these recommendations were APPROVED.

**AC29**—Resolution AC'66 No. 6 was presented: –

**AC'66 No. 6:**
Moved by Dr. A. L. Murphy
Seconded by Dr. A. J. M. Griffiths
"That the Society express its appreciation to Dr. J. F. Filbee for his excellent work as Editor of The Nova Scotia Medical Bulletin." CARRIED.

**AC30—Report Of The Medical-Legal Liaison Committee:** (AR p. 23-25) Chairman, Dr. I. D. Maxwell.

The report dealt with the following subjects: – 1. Battered Children; 2. Breath Alcohol Analysis; 3. Medical-Legal Panel Discussions on Problems and Reports.

**AC31**—On motion by Dr. Maxwell, seconded by Dr. Devereux the report was accepted for information.

**AC32—Recommendations.**

1. "That the Committee on Medical-Legal Liaison be continued."

On motion by Dr. Maxwell, seconded by Dr. Robinson this recommendation was APPROVED.

2. "That consideration be given to the conduction of a regular column in The Nova Scotia Medical Bulletin devoted to Medical-Legal Enquiries." On motion this was APPROVED.
3. "That Maritime Medical Care Inc. be approached concerning coverage of medical-legal reports as an insured item."

**AC33**—The Council was informed that discussion had taken place on this recommendation at the Annual Meeting of the Executive Committee which had resulted in AE'66 No. 5: –

**AE'66 No. 5:**
Moved by Dr. T. W. Gorman
Seconded by Dr. H. I. MacGregor
"That recommendation 3 of AR59 be deleted from the report because the Medical Society is on record as not being in favour of the inclusion of such benefits under a comprehensive plan. CARRIED.

**AC34**—After further discussion Dr. Maxwell agreed to deleting recommendation 3 from the report.

4. "That the Medical Society make official representation to the Attorney General of Nova Scotia indicating that the principle of voluntary breath analysis of drinking drivers provided no satisfactory solution to the problem of driving impairment due to alcohol." Moved for adoption by Dr. Maxwell, seconded by Dr. R. P. Belliveau. CARRIED.

**AC35**—Discussion as to the most effective method of implementing resolution No. 4 resulted in presentation of 3 resolutions: –

**Resolution AC'66 No. 7:**
Moved by Dr. I. Maxwell
Seconded by Dr. G. D. Belliveau
"That The Medical Society of Nova Scotia recommend to the Attorney General of Nova Scotia: –
'That an amendment be enacted to the Motor Vehicle Act of Nova Scotia, making it an offence against the Act for a person having the control of a motor vehicle to have a blood alcohol level in excess of 0.10% as estimated by breath alcohol analysis'."
CARRIED.

**Resolution AC'66 No. 8:**
Moved by Dr. I. Maxwell
Seconded by Dr. G. D. Belliveau, as amended by Resolution AC'66 No. 10: –
Moved by Dr. I. E. Purkis
Seconded by Dr. S. C. Robinson
"That the results of breathalizer tests be admitted as part of the evidence in court when a person is being investigated or charged for an offence against the Criminal Code of Canada." CARRIED.

**AC36**—The amendment (AC'66 No. 10) changed the words in resolution AC'66 No. 9 from "- - for an offence against the Motor Vehicle Act of Nova Scotia". to "- - in case of an offence against the Criminal Code of Canada".

**AC37**—It was moved by Dr. Steeves, seconded by Dr. F. G. Bell that the preceding motions be referred to the Resolution Committee for final examination of wording.

**AC38**—There being no Old Business, or New Business; the Chairman, Dr. A. J. M. Griffiths adjourned the 1st Session of Council at 1.10 p.m., stating that there would be an informal luncheon in the Imperial Ballroom and that ladies are welcome.

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## SECOND SESSION OF COUNCIL

**AC39**—The 2nd Session of the Council was convened at 2.15 p.m. with the President, Dr. A. J. M. Griffiths in the Chair.

The presentation of the Reports of Committees and representatives was continued.

**AC40—Report Of Special Committee On Review Of Committee Structure:** (AR p. 42), Chairman, Dr. C. E. Kinley.

Dr. Kinley presented his report, stating that the only matter of importance was consideration of the advisability of establishing a "Standing Committee on Hospital Privileges" which had been previously suggested.

**Resolution AC'66 No. 11: -**

Moved by Dr. C. E. Kinley

Seconded by Dr. J. K. Purves

"That the Council instruct the Executive Committee to study the advisability of establishing a Hospital Privileges Committee." CARRIED.

**AC41**—Dr. Kinley moved, seconded by Dr. E. Grantmyre that the report be accepted for information. CARRIED.

**AC42—Committee On Nutrition:** (AR p. 28-29), Chairman, Dr. C. F. Brennan.

The report reviewed "one aspect of nutrition, namely, anemia, particularly iron deficiency anemia, which is undoubtedly the most common deficiency disease in our population". It was moved by Dr. Brennan, seconded by Dr. S. C. Robinson that the report be accepted for information. CARRIED.

**AC43—Recommendations.**

"Since most people with iron deficiency are women in the child-bearing age, the haemoglobin should be checked in each trimester, not just during the first prenatal visit. If the haemoglobin is below 12 gms. % on the fourth day post partum, iron should be taken, prescribed aggressively by the physician for several weeks or months.

Menorrhagia must be treated not only with curettages and hormones, etc., but also with iron.

Since the physicians in practice will probably not change their habits, greater emphasis must be placed on this common condition in the medical school curriculum so that the future generation of doctors will treat anemia aggressively and intelligently without the advice of pharmaceutical companies. Vitamins are relatively expensive, usually unnecessary. Iron is cheap and the correct treatment for iron deficiency anemia."

**AC44**—On motion of Dr. Brennan, seconded by Dr. G. R. Greening, these recommendations were ADOPTED.

**AC45—Annual Report Of Committee On Child Health:** (AR p. 6-8), Chairman, Dr. B. S. Morton.

Dr. Morton presented his report which ended in a summary as follows: -

"(1) An up-to-date brief review of the work of the Rh Committee in combating erythroblastosis was given. A plea was made for more physicians to refer for opinion, information on any mother who has antibodies.

(2) The value of the Guthrie Test for Phenylketonuria was re-emphasized, with the recommendation that it be made available to all babies born in this Province. Since the program started, six cases have been detected.

(3) The need for up-to-date information regarding standards of care for newborn nurseries, with special emphasis on premature and sick newborn infants. A forthcoming project could be to have this data available in all hospitals in the Province where babies are being delivered and/or treated.

(4) The problem of sudden death in infancy was discussed, with a plea for entering on the death certificate a diagnosis of "Sudden unexpected death" whenever it happens, no matter whether it is explained or not.

(5) School health problems were discussed, with special reference to the pre-school health examinations. There are no specific recommendations to be made at this time. The report is mainly for information."

**AC46**—On motion of Dr. Morton, seconded by Dr. Ian MacGregor, the report was ACCEPTED for information.

**AC47—Committee On Fees:** (AR p. 85-86), Chairman, Dr. H. C. Still.

Dr. Still spoke to each of the ten points having to do with the preparation of the new Schedule of Fees and answered questions. He also informed the Council on the latest development in the study of a Relative Value Schedule. On motion by Dr. Still, seconded by Dr. Robinson, this report was ACCEPTED for information. The Chairman of Council conveyed to Dr. Still and his Committee an expression of thanks for the work which has been, and is being done.

**AC48—Committee On Aging:** (AR p. 88-89), Chairman, Dr. A. A. MacDonald.

In presenting the report Dr. MacDonald reviewed the development of interest in the aging. He requested that this report be referred to the Executive Committee for consideration of the recommendation that the Nova Scotia Committee on Aging be disbanded but that a representative from Nova Scotia continue to represent this Division on the C.M.A. Committee on Aging with an annual report be presented to the Society by the Divisional representative. On motion, the report of the Committee on Aging was ACCEPTED for information.

**AC49—Committee On Rehabilitation:** (AR p. 42), Chairman, Dr. L. S. Allen.

This report informed Council that there had been no activity on the part of this Committee in the past year. On motion, this was ACCEPTED for information.

**AC50—Committee On Cancer:** (AR p. 82-84), Chairman, Dr. G. W. Bethune.

The report, in the absence of Dr. Bethune, was presented by Dr. Myrden. It was noted that the Chairman of the Society's Committee on Cancer is also the representative to the Nova Scotia Division of the Canadian Cancer Society. A tribute was paid to Dr. Ian MacKenzie who had been Chairman of the Committee up to the time of his recent death. There was a general review of recent information relating to cancer. Dr. Myrden moved, and Dr. Robinson seconded, that the report be accepted for information. CARRIED.

**AC51—Recommendations.**

"(1) It is recommended that the cytology programme should receive the continued support of the medical profession, and that this should be made a routine part of the examination on women at risk for this disease.

(2) With regard to education it is recommended that branches of the Cancer Society receive the co-operation of medical practitioners in their vicinity, particularly in the way of commenting on the education movies and the other efforts of the Cancer Society branch. It is recommended that the co-operation of the Provincial Cancer Registry continue as it has in the past."

**AC52**—On motion by Dr. Myrden, seconded by Dr. Ian MacGregor, the two recommendations were ADOPTED.

**AC53—Committee On Legislation & Ethics:** (AR p. 17-18; supplementary report p. 87), Chairman, Dr. H. K. Hall.

The report gave information relative to events during the year including opposition by the Society to proposed chiropractic legislation placed before the Legislature (1966). The Bill had been defeated at Second Reading by support of an amendment to delay Third reading to six months hence. He reported that the Medical Society had been approached since then by the chiropractors for discussions about proposed legislation and that the Executive approved of such discussions and these would continue.

Temporary registration of physicians with the Provincial Medical Board had been examined and that the Committee feels the present legislation is reasonably satisfactory. Finally, that the Society should give strong support to the review of the functions and operation of the Provincial Medical Board.

It was moved by Dr. Hall and seconded by Dr. Archibald that this report be accepted for information.

**AC54**—During discussion, Council was informed of Resolution RE5'66 No. 12: –

**RE5'66 No. 12:**

Moved by Dr. G. McK. Saunders

Seconded by Dr. C. D. Vair

"That the Committee on Legislation & Ethics be asked to outline those features which would be acceptable to The Medical Society of Nova Scotia in legislation governing the practice of Chiropractic in Nova Scotia." CARRIED.

**AC55**—The Second Session of Council was recessed by the Chairman at 3.45 p.m., informing the members that coffee would be served in the Exhibitor's area.

**AC56**—The Second Session of Council was re-convened at 4.15 p.m.

**AC57—Committee On The Medical Aspects of Traffic Accidents:** (AR p. 43-44), Chairman, Dr. H. H. Tucker.

The report was divided into two Sections. The first dealt with improved handling of the accident problem including the Trauma Team and ambulances; section two reviewed items designed to reduce accidents and included information on legislative committee, alcohol and the driver, new cars coming to Nova Scotia, physical fitness guide, and finally publicity. Dr. Tucker moved, seconded by Dr. Devereux, that this report be received for information. There was a lengthy discussion which resulted in the following resolutions.

**AC'66 No. 12:**

Moved by Dr. S. H. Kryszek

Seconded by Dr. G. W. Turner

"That the Society recommend to the Provincial Government that wearing crash helmets be again made mandatory for motor-cycle riders." CARRIED.

**Resolution AC'66 No. 13: -**

Moved by Dr. C. E. Kinley

Seconded by Dr. J. Williston

"That The Medical Society approach the Department of Public Health for financial support in the training of Trauma Teams." CARRIED.

**Resolution AC'66 No. 14: -**

Moved by Dr. E. Grantmyre

Seconded by Dr. J. A. Smith

"That this Society go on record for the strict enforcement of the existing laws governing motor-vehicle travel in this province in an attempt to reduce the needless slaughter on our highways." CARRIED.

**AC58—Reports received for information: -**

**Report Of Representative To Trusteeship Committee C.M.A.R.S.P. & C.M.A.E.F.:**
(AR p. 62-65), Dr. C. H. Young

**Medical Advisory Board Of Nova Scotia Tuberculosis Association:** (AR p. 60-61) Dr. R. L. Aitken

**Representative To Dalhousie Medical Library:** (AR p. 90), Dr. D. E. Lewis

**Board Of Registration Certified Nursing Assistants:** Dr. C. J. W. Beckwith

**Provincial Liaison Committee On Nursing:** Dr. R. M. Macdonald

**Medical Advisory Committee On Drivers Licensing:** Dr. H. K. Hall

**AC59—Committee On Public Health:** (AR p. 38-39), Chairman, Dr. W. I. Bent.

The report included the latest information on Vitamin D. and Vitamin C. as published in the April 1966 issue of The Nova Scotia Medical Bulletin which, on motion, was received for information. Part two dealt with "Proposed Personnel Health Policies in Hospitals" which had been reviewed by the Annual Meeting of the Executive Committee resulting in resolution AE'66 No. 8: –

**AE'66 No. 8:**

Moved by Dr. D. C. Cantelope

Seconded by Dr. A. J. M. Griffiths

"That the Recommendations presented in the report of the Committee on Public Health be approved by the Executive Committee." CARRIED.

**AC60**—The Personnel Health Policies in Hospitals are as follows:

"1) Examination of all hospital employees for evidence of active pulmonary tuberculosis must be carried out on a regular basis. Employees must be Tuberculin Tested and X-rayed (if Tuberculin positive) at least yearly. New employees shall be examined one week of commencing duty.

2) The maximum possible percentage of admission chest X-ray examinations must be maintained. Exempt are those patients under 16 years of age and those having received a previous chest X-ray within a period of six months.

3) Routine blood serology for the detection of syphilis must be continued for all hospital admissions and newborns.

4) Vaccination against smallpox must be carried out at least every three years on all hospital employees (except those who present exempting medical certificates).

5) All Medical Students, Interns, Nurses, Nursing Assistants, X-ray Technicians, Laboratory Technicians and Physiotherapists who have a negative Tuberculin Test should receive B.C.G. vaccine.

6) All hospital employees should be encouraged to receive protection against Tetanus and Poliomyelitis. Protection against these diseases is obtained by the use of combined Tetanus Toxoid and Poliomyelitis Vaccine. For primary immunization it is recommended that three subcutaneous doses be administered with an interval of four to six weeks between the first, second and third doses, and a re-inforcing dose six to twelve months following the third dose.

7) As a routine procedure, at least one and preferably two specimens of sputum for smear and culture shall be forwarded to the Provincial Laboratory for evidence of Tubercle Bacilli from any expectorating patient.

8) At least one specimen of feces shall be forwarded to the Provincial Laboratory for evidence of pathogens from any patient suffering from diarrhoea.

9) All food handlers shall have at least one stool examination for evidence of pathogens either before or immediately after commencing employment.

10) A health record for all employees shall be maintained. Such record shall indicate previous illness, date and place of chest X-ray examinations, results of tuberculin testing, Smallpox and B.C.G. vaccinations, inoculations against Diphtheria, Tetanus, Poliomyelitis, Typhoid and Paratyphoid Fevers, results of stool examinations for pathogens."

On motion the recommendations were approved.

**AC61**—Dr. J. B. MacDonald moved, seconded by Dr. H. J. Devereux that the following Annual Reports be received for information: –

1) **Federal-Provincial Health Grants:** (AR p. 75), Dr. C. J. W. Beckwith.
2) **Medical Education:** (AR p. 71), Dr. J. A. McDonald.
3) **Committee On By-Laws:** (AR p. 5), Dr. J. E. Hiltz
4) **Committee On Insurance:** (AR p. 70), Dr. P. B. Jardine
5) **Committee On Archives:** (AR p. 4), Dr. D. R. MacInnis
6) **Committee On Occupational Medicine:** (AR p. 31), Dr. J. C. Wickwire

Motion CARRIED.

**AC62—Recommendations**

Dr. Wickwire moved and Dr. Gorman seconded, that the recommendations of the Committee on Occupational Medicine be adopted, the recommendations being: –

(1) "That the plan of routine physical examinations, within the various industrial plants, be ecouraged,
(2) that the Saint John Ambulance program be extended to more industries within the Province,
(3) that safety measures, as mentioned, together with many others, be developed." CARRIED.

**AC63—Representative To The Board Of Governors, Victorian Order Of Nurses:** (AR p. 66), Dr. G. M. Smith.

On motion this report was accepted for information. At the Annual Executive Meeting a discussion of the role of the V.O.N. led to the presentation of resolution AE'66 No. 9: –

**AE'66 No. 9:**
Moved by Dr. N. Glen
Seconded by Dr. T. W. Gorman

"That it is recommended that our representative to the V.O.N. Board of Governors, the Committee on Public Health, and the Section for General Practice, jointly formulate suggestions for the future roles of the V.O.N. Nurses bearing in mind the changes taking place in the concepts of Family Practice." CARRIED.

**AC64—Committee On Civil Disaster:** (AR p. 3-4), Chairman, Dr. S. H. Kryszek.

Dr. Kryszek moved that the report be accepted for information, seconded by Dr. Filbee. CARRIED.

Out of discussion resolution AC'66 No. 15 was presented: –

**AC'66 No. 15:**
Moved by Dr. S. H. Kryzek
Seconded by Dr. J. F. Filbee

"That the Society re-endorse the recommendations of the Civil Disaster Committee made to Council in 1965." CARRIED.

**AC65**—(The RECOMMENDATIONS referred to are: –
That the following procedures should be taught in the School of Nursing: –

"1. Intravenous procedures – (a) diagnostic
(b) therapeutic
2. Splinting of fractures of all types which require splinting.
3. Emergency obstetrical delivery.

The performance of the above procedures by nurses is only for a declared emergency in an existing hospital or for work in an emergency Health unit of the Emergency Health Services. Otherwise performance of these procedures will be subject to the policy of the individual existing hospitals and/or practising physicians.

We further recommend that, if these suggestions are acceptable, they should be passed to the Liaison Committee on Nursing for further action.")

**AC66—Committee On Physical Education & Recreation:** (AR p. 33-35), Chairman, Dr. J. K. Purves.

Dr. Purves reviewed his report, moving that it be accepted for information. Seconded by Dr. Robinson and CARRIED.

**AC67**—The Chairman of Council announced that the *Summer Meeting* for 1967 would be held at the Pines Hotel, Digby, July 1st – 4th, 1967. Plans are to have the Annual Meeting take place in Sydney in November.

**AC68—Committee On Mediation:** (AR p. 19), The Chairman, Dr. A. J. M. Griffiths, presented this report. On motion, it was received for information.

**AC69—Report Of Representatives To Provincial Medical Board:** (AR p. 91), Dr. D. R. Campbell.

Dr. Gorman moved, seconded by Dr. Ian MacGregor that the report be accepted for information.

**AC70**—The attention of Council was drawn to Resolution from the Executive Committee namely AE'66 No. 3: –

**AE'66 No. 3**
Moved by Dr. T. W. Gorman
Seconded by Dr. H. I. MacGregor

"That the Executive of the Medical Society is very favourably impressed with the spirit of liaison shown between the Provincial Medical Board and the Medical Society." CARRIED.

**AC71—Report from The Section For General Practice:** (AR p. 66-67), Chairman, Dr. D. C. Brown.

This report informed Council of the activities of the Section. On motion by Dr. Brown, seconded by Dr. Devereux, the report was received for information.

**AC72—Section For Psychiatry:** (AR p. 68-69), Chairman, Dr. R. Parkin.

Dr. Parkin reviewed the report. The summary states: –

1) "The Section for Psychiatry is concerned regarding the permanent location of a school for boys in an area deficient in the necessary personnel, facilities etc.
2) The members of the Section for Psychiatry recognize the need for a greater spectrum of services for children."

On motion by Dr. Parkin, seconded by Dr. MacGregor the report was received for information. The 3 recommendations in the report were now considered.

**AC73—Recommendations.**

1. That the Council of The Medical Society of Nova Scotia publicly express dissatisfaction with the present plan to permanently locate the Nova Scotia School for Boys in Shelburne - an area where non-medical personnel and services are inadequate to meet the need of the children involved.

Discussion resulted in resolution AC'66 No. 16: –

**AC'66 No. 16:**
Moved by Dr. R. Parkin
Seconded by Dr. A. A. MacDonald

"That whereas the Minister of Public Welfare has announced that permanent quarters for the Nova Scotia School for Boys will be established in Shelburne, Nova Scotia; and whereas the Section for Psychiatry of The Medical Society of Nova Scotia believes this move to be contrary to modern trends in criminology; and whereas the Society considers that Shelburne lacks the necessary personnel and services.

Be it resolved that the Council of The Medical Society of Nova Scotia express dissatisfaction with the present plan to permanently locate the Nova Scotia School for Boys in Shelburne."

On vote this motion was DEFEATED.

**Resolution AC'66 No. 17** was now presented: –
Moved by Dr. J. A. Smith

Seconded by Dr. T. W. Gorman

"That The Medical Society of Nova Scotia strongly recommend to the Minister of Public Welfare that every effort be made to provide adequate psychiatric facilities for the Nova Scotia School for Boys at Shelburne." CARRIED.

**AC74—Report Of Section For Salaried Physicians:** (AR p. 78), Chairman, Dr. W. A. Cochrane.

Dr. Cochrane presented this report. On motion para AR260 was deleted. The report was, on motion of Dr. Cochrane, seconded by Dr. Rideout, accepted for information.

**AC75—Recommendations** were now considered as follows: –

(a) "That the Society make necessary arrangements to activate the C.M.A. proposal regarding collective bargaining for salaried physicians."

On motion of Dr. Cochrane, seconded by Dr. S. C. Robinson this recommendation was APPROVED.

(b) "That the Society arrange for publication in the new Fee Schedule a Section on Salaries for Salaried Physicians that may be used as a guide for government, industry and others employing physicians for administrative and /or professional responsibilities."

On motion of Dr. Cochrane, seconded by Dr. D. Robb this recommendation was APPROVED.

During discussion it was noted that action had already been initiated in relation to both of these recommendations.

**AC76**—On motion the 2nd Session of Council was adjourned at 5.00 p.m.

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## THIRD SESSION OF COUNCIL

**AC77**—The Chairman, Dr. A. J. M. Griffiths convened the 3rd Session of Council at 9.15 a.m. He expressed pleasure in introducing Mr. W. R. Stevenson, President, Dalhousie Medical Students Society.

Annual Reports of Committees were continued.

**AC78—Workmen's Compensation Board Liaison Committee:** (AR p. 45), Chairman Dr. M. E. Delory.

Dr. DeLory presented his report, and moved, seconded by Dr. Purves, the report be accepted for information. CARRIED.

**AC79—Recommendations** from the report were now considered individually as follows: –

"Although the Workmen's Compensation Board is governed by the Workmen's Compensation Act of Nova Scotia, we believe that a better liaison between The Medical Society of Nova Scotia and the Workmen's Compensation Board would exist if the members of the Society would accept the following recommendations: –

1. Have a more accurate knowledge of the fee schedule.
2. Be more accurate in reporting and in the submission of claims.
3. To determine the eligibility of claims whenever possible.
4. To question any irregularities.
5. To inform the Liaison Committee of The Medical Society of Nova Scotia of any irregularities or need for assistance.

On motion by Dr. DeLory, seconded by Dr. Purves these recommendations were APPROVED.

**AC80—Committee On Medical Economics:** (AR p. 20-22), Chairman Dr. D. C. Brown.

The report was presented under the following headings: –

1. Negotiation with the Department of Public Welfare, Province of Nova Scotia.
2. Arrangements with Maritime Medical Care Inc. relative to the Welfare Group.
3. Report of matters referred to the Executive Committee during the year.
4. Consideration of matters presented by the Canadian Medical Association Committee on Economics.

Dr. Brown moved, seconded by Dr. H. E. Christie, that the report be received for information. CARRIED.

**AC81—Recommendations** were now considered as follows: –

1. "To continue efforts to increase the number of Welfare recipients eligible for physicians' services insurance under the agreement between the Medical Society and the Department of Public Welfare."

Moved by Dr. Brown, seconded by Dr. Devereux that recommendation 1 be adopted. CARRIED.

2. "To continue negotiations with the Department of Public Welfare, the Province of Nova Scotia, to have the amount of money per beneficiary in the Welfare Group increased."

Moved by Dr. Brown, seconded by Dr. Reid that recommendation 2 be adopted. CARRIED.

**AC82**—Dr. Brown expressed his thanks to Council for the opportunity of representing the Medical Society at C.M.A. level as well as being Chairman of the Divisional Committee and regretfully tendered his resignation as Chairman of the Committee.

**AC83**—Dr. Parkin referred to para AR52 (C) "Should we honor private accounts, submitted from physicians who are in the employ of Mental Health Centres throughout the province, on Welfare beneficiaries." Dr. Parkin was informed that this is to be referred to the Section for Psychiatry for study and advice.

**AC84**—The Chairman introduced Mr. W. J. MacInnes, Q.C. Legal Counsel to the Society and the Physicians' Services Insurance Committee.

**AC85—Committee On Hospitals:** (AR p. 79-81), Chairman, Dr. J. A. Smith.

Dr. Smith reviewed his report which dealt with discussions with the Nova Scotia Hospital Association and the Nova Scotia Hospital Insurance Commission relative to remuneration for Pathologists and Radiologists, and the use of Flame Photometers in smaller hospitals. Our Section for Pathology had advised that it "- - would support the use of a Flame Photometer in any laboratory where the regional pathologists felt that the technician was competent to use the instrument and provided that the pathologist was willing to accept responsibility for the work of that technician."

Dr. Smith moved, seconded by Dr. D. C. Brown, the report be received for information. CARRIED.

**AC86**—There was lengthy discussion of the proposed formula for remuneration to Pathologists and Radiologists proposed to be effective January 1st 1967. The Annual Meeting of the Executive Committee had directed that resolution RE5'66 No. 14 be placed before the Council.

**RE'66 No. 14:**

Moved by Dr. A. J. M. Griffiths

Seconded by Dr. J. K. Purves

"That the Executive Committee sees no objection to the proposal for remuneration of Pathologists and Radiologists provided they are acceptable to the specialists concerned." CARRIED.

Dr. S. C. Robinson moved, seconded by Dr. J. A. Smith that resolution RE5'66 No. 14 be adopted by Council. CARRIED.

**AC87—Report Of Maritime Medical Care Inc.:** (AR p. 55-59), President, MMC., H. B. Whitman, M.D.

Dr. Whitman read the informative report and moved that it be accepted for information; seconded by Dr. I. MacGregor. CARRIED.

Mr. Brannan and Dr. Titus replied to questions on participating physicians and on the items of the Fee Schedule

which remain on the negotiated list. The latter discussion resulted in resolution AC'66 No. 19: -

**AC'66 No. 19:**

Moved by Dr. S. C. Robinson

Seconded by Dr. G. Silver

"That this Council request its members on the MMC Board of Directors to take the necessary steps to adjust the negotiated fee items listed in MMC's June Bulletin to the level of the Fee Schedule of The Medical Society of Nova Scotia." CARRIED.

**AC88**—The Chairman of Council now introduced and welcomed the Honorable R. A. Donahoe, Minister of Public Health, Nova Scotia.

**AC89**—The meeting recessed for coffee in the exhibitors space.

**AC90**—The 3rd Session of Council '66 was reconvened at 11.20 a.m. Dr. S. C. Robinson, Chairman of the Executive Committee, chaired the meeting while Dr. A. J. M. Griffiths as Chairman of the Physicians' Services Insurance Committee presented the report.

**AC91—Physicians' Services Insurance Committee:** (N.B. Bill C-227 received 3rd reading in the House of Commons December 8 /66.) (AR p. 36-37), Chairman, Dr. A. J. M. Griffiths.

Dr. Griffiths reminded Council that copies of the 18 Memoranda had been forwarded to all members of Council together with the resolutions from the 5th Regular Meeting of the Executive Committee (October 22nd 1966). He stated that Memorandum No. 19 "Application of the Fee Schedule" (November 20th 1966) has been distributed to members of Council at this meeting.

**AC92**—He also stated that the P.S.I Committee wished to have para AR111 replaced by the following which results from discussion and was approved at the Executive Committee Meeting, November 24th;

"A Fee Schedule may be said to perform three functions: –

a) Provide a list of services and procedures.

b) Indicate the relative value of such services and procedures.

c) Give a price list for such services and procedures.

We feel that items (a) and (c) under a Medicare Plan could possibly be a matter for negotiation, but item (b) must remain in the hands of the profession for alteration when necessary.

Adjustments to the overall costs of physicians' services under the programme could be subject to regular review and the application of the mutually acceptable index reflecting changes in economic circumstances."

Dr. Griffiths proceeded to outline each item in his report and having done so, moved that the report be accepted for information, seconded by Dr. H. J. Devereux. CARRIED

Questions were answered, and considerable discussion ensued on para AR109, AR110 and the replacement of AR111.

**AC93**—A resolution was presented from the Lunenburg-Queens Medical Society Meeting (November 20th), which proposes an amendment to Memorandum No. 7 "Physicians' collection costs under Medicare versus private patient billing";

Moved by Dr. G. C. Jollymore

Seconded by Dr. D. C. Langille

"That the Medical Society through the Physicians' Services Insurance Committee recommend to government that medicare be implemented by a contractual relationship between patient and government to reimburse the patient for receipted medical accounts and that there be no contractual relationship between government and the doctor."

Dr. Jollymore distributed a prepared statement which had been the basis for this resolution. Following lengthy discussion it was regularly moved and seconded that the resolution from the Lunenburg-Queens Medical Society be REFERRED to the Executive Committee.

**AC94**—Two additional resolutions were presented namely: –

**Resolution AC'66 No. 21:**

Moved by Dr. G. McK. Saunders

Seconded by Dr. A. J. M. Griffiths

"That Dr. C. L. Gosse be appointed a member of the Physicians' Services Insurance Committee to replace Dr. A. Sutherland on his election as President-Elect." CARRIED.

**Resolution AC'66 No. 22:**

Moved by Dr. N. G. Glen

Seconded by Dr. G. C. Jollymore

"That the Council and members of The Medical Society of Nova Scotia record a sincere and hearty vote of thanks to the Members of the P.S.I. Committee for their valuable efforts on behalf of our profession in Nova Scotia." CARRIED.

**AC95—Old Business**

Resolution AC'66 No. 2, had been presented and carried to the 1st Session of Council. At that time it was requested that the subject of the location for C.M.A. House be brought up during the 3rd Session. Discussion resulting from the reintroduction of the subject led to resolution AC'66 No. 24: –

**AC'66 No. 24:**

Moved by Dr. D. F. Smith

Seconded by Dr. A. A. MacDonald

"That The Medical Society of Nova Scotia recommend to the Executive of C.M.A. that a C.M.A. House be constructed in the Ottawa area." CARRIED.

**AC96—New Business**

Dr. C. E. Kinley, expressing concern about the shortage of nurses in Nova Scotia, proposed resolution AC'66 No. 23: –

**AC'66 No. 23:**

Moved by Dr. C. E. Kinley

Seconded by Dr. T. W. Gorman

"That whereas the shortage of nursing staff is evident in Nova Scotia and this shortage is likely to become more acute in the next few years when current hospital building programme is completed, and:

Whereas we see little evidence of a plan to increase the number of nursing graduates in the near future, and:

Whereas despite attempts to correct 'maldistribution' of nurses, and despite the increase due to utilization of nursing assistants there is evidence of a developing crisis in 'patient care'

Be it resolved that the Executive Committee consider the various facets of this problem especially as they relate to university and hospital nursing school programmes, the competence and supply of nursing staff, the cost of training and the remuneration of trained nurses. The Executive Committee is requested to take such action as it deems necessary through the Society's contacts with interested parties, including the Nurses Association and the Nova Scotia Hospital Insurance Commission, to resolve this situation." CARRIED.

**AC97**—There being no further business the third Session of Council 1966 was, on motion adjourned at 12.55 p.m. □

# 113th Annual Meeting

**FIRST SESSION**

**Friday, November 25th, 1966, 5.00 p.m.**

**Lord Nelson Hotel, Halifax**

**AM1**—The 1st Session of the Annual Meeting was convened by the President, Dr. A. J. M. Griffiths at 5.00 p.m. Dr. Griffiths stated that the purpose of this Session was to receive the report of the Nominating Committee and to elect officers, representatives and alternates to the Nova Scotia Executive Committee, representative and alternate to the C.M.A. Executive Committee, and representatives to the Provincial Medical Board.

**AM2**—Dr. Griffiths invited Dr. T. W. Gorman, Past-President, to Chair the meeting while he, as Chairman of the Nominating Committee, made his report, as follows: –

**Officers of the Society**

President – Dr. G. McK. Saunders

President Elect – Dr. A. L. Sutherland

Past President – Dr. A. J. M. Griffiths

Chairman of the Executive Committee – Dr. S. C. Robinson

Vice Chairman of the Executive Committee – Dr. J. H. Charman

Honorary Treasurer – Dr. C. D. Vair

Honorary Secretary – Dr. F. G. Mack

**Branch Representatives and alternate to the Executive Committee**

| | | |
|---|---|---|
| Antigonish-Guysborough | — Dr. G. Silver<br>Alternate<br>Dr. J. A. MacCormick | |
| Cape Breton | — Dr. J. B. Tompkins<br>Alternate<br>Dr. C. A. D'Intino<br>Dr. J. A. McPhail<br>Alternate<br>Dr. N. K. MacLennan | |
| Colchester East Hants | — Dr. H. D. Lavers<br>Alternate<br>Dr. A. Elmik | |
| Cumberland | — Dr. N. G. Glen<br>Alternate<br>Dr. H. E. Christie | |
| Dartmouth | — Dr. W. F. Verge<br>Alternate<br>Dr. C. H. Young | |
| Eastern Shore | — Dr. P. B. Jardine<br>Alternate<br>Dr. E. A. MacKenzie | |
| Halifax | — Dr. J. H. Charman*<br>Alternate<br>Dr. C. H. Graham | |
| | — Dr. J. K. Purves<br>Alternate<br>Dr. D. E. Morris | |
| | — Dr. H. C. Still | |
| Inverness-Victoria | — Dr. C. L. MacMillan<br>Alternate<br>Dr. C. S. Macdonald | |
| Lunenburg-Queens | — Dr. D. C. Cantelope<br>Alternate<br>Dr. D. A. Campbell | |
| Pictou County | — Dr. J. B. MacDonald<br>Alternate<br>Dr. C. A. Robertson | |
| Shelburne | — Dr. F. Markus<br>Alternate<br>Dr. M. T. Cooper | |
| Valley | — Dr. D. J. G. Morris<br>Alternate<br>Dr. C. E. Jebson | |
| Western N. S. | — Dr. M. W. O'Brien<br>Alternate<br>Dr. G. D. Belliveau | |

*The Halifax Medical Society will nominate a replacement because Dr. Charman is nominated Vice Chairman of the Executive Committee.

**Nominating Committee (1966-1967) to report to the 114th Annual Meeting, November 24th and 25th, 1967.**

| | | |
|---|---|---|
| Antigonish-Guysborough | — | Dr. Rolf Sers<br>Alternate<br>Dr. J. R. Greening |
| Cape Breton | — | Dr. J. R. Macneil<br>Alternate<br>Dr. J. A. McDonald |
| Colchester East Hants | — | Dr. T. C. C. Sodero<br>Alternate<br>Dr. M. Bruce |
| Cumberland | — | Dr. H. Christie<br>Alternate<br>Dr. D. R. Davies |
| Dartmouth | — | Dr. F. J. Barton<br>Alternate<br>Dr. G. Pace |
| Eastern Shore | — | Dr. A. C. Marshall<br>Alternate<br>Dr. H. Earle |
| Halifax | — | Dr. H. C. Still<br>Alternate<br>Dr. B. J. Steele |
| Inverness-Victoria | — | Dr. C. B. MacLean<br>Alternate<br>Dr. C. L. MacMillan (Sr.) |
| Lunenburg-Queens | — | Dr. G. C. Jollymore<br>Alternate<br>Dr. D. B. Keddy |
| Pictou | — | Dr. R. G. Munroe<br>Alternate<br>Dr. J. F. Hamm |
| Shelburne | — | Dr. T. S. Mears<br>Alternate<br>Dr. M. T. Cooper |
| Valley | — | Dr. G. W. Turner<br>Alternate<br>Dr. D. G. Black |
| Western N.S. | — | Dr. R. P. Belliveau<br>Alternate<br>Dr. M. W. O'Brien |

**Nova Scotia Representative To Executive Committee, Canadian Medical Association.**

Nominee – Dr. A. J. M. Griffiths. (This nomination from Nova Scotia is presented to the Annual Meeting of the C.M.A. in June 1967 at which time election takes place with attendance of the representative or alternate at the first meeting of the C.M.A.)
Alternate – Dr. C. L. Gosse.

**Provincial Medical Board for the term 1966 - 1969.**

Dr. D. R. Campbell (re-appointed for 2nd term).
Dr. J. F. Nicholson (new appointment).

**AM3**—The Chairman asked for other nominations from the members. A motion that nominations cease was seconded and carried, following which the Chairman declared the nominees elected. There being no other business, the 1st Session of the 113th Annual Meeting was adjourned at 5.30 p.m.

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## SECOND SESSION

**Saturday, November 26th, 1966**

**1.00 p.m.**

**Lord Nelson Hotel Halifax**

**AM4**—Following adjournment of the Council 1966 the President, Dr. A. J. M. Griffiths, asked the opinion of the members as to whether the 2nd Session of the Annual Meeting should be convened now or at the hour of 2.00 p.m., as scheduled. There was agreement to have the 2nd Session of the Annual Meeting convened.
The President convened the 2nd Session of the Annual Meeting 1966 at 1.00 p.m.

**AM5**—The President indicated that the By-Law, Chapter IX "Council" Article I - "Duties and Powers of Council" reads: "The Council shall be the governing body of the Society with its actions subject to the approval of the Society at its Annual Meeting. It shall report to the membership at the Annual Meeting of the Society and, as warranted, through the pages of The Nova Scotia Medical Bulletin."

**AM6**—Dr. H. J. Devereux, Chairman Resolution Committee, reported that the discussions of Council on reports of Standing Committees, Special Committees and representatives had resulted in 24 resolutions being presented and voted on. The President asked if any member wished to have reviewed any resolution or any report.

**Resolution AM'66 No. 1** was presented: –
Moved by Dr. S. C. Robinson
Seconded by Dr. F. A. Dunsworth
"That the Annual Meeting accept the resolutions and reports of the 1966 Session of Council of The Medical Society of Nova Scotia." CARRIED.

**AM7**—The President announced that some difficulty was being experienced in finalizing arrangements to have the Clinical Sessions, the Meeting of Council and the Annual Meeting 1967 in Sydney. Discussion resulted in Resolution AM'66 No. 2: -

**Resolution AM'66 No. 2:**
Moved by Dr. D. R. Campbell
Seconded by Dr. K. Hayes
"That unless the Executive Committee is able to arrange that the Annual Refresher Course (Clinical Sessions) be held in Sydney in 1967 that the next meeting of Council be held in conjunction with the Refresher Course in Halifax." CARRIED.

**AM8**—The President asked if there was any additional business to bring to the attention of the Annual Meeting. Some member introduced a verbal vote of thanks which was promptly seconded and received applause.

**AM9**—On motion the 113th Annual Meeting of The Medical Society of Nova Scotia was adjourned at 1.30 p.m. □

# 114th Annual Meeting

The third Meeting of The Medical Society of Nova Scotia and the 114th Annual Meeting of this Society will be held on November 24th and 25th.

These meetings at this time in our history are particularly important and many matters, some of which are referable to our By-Laws and policy, will have to be discussed and decided upon.

The first two meetings of our Council have demonstrated the value of this body and it is hoped that as many as possible of our membership will be in attendance, whether or not they are representatives to council.

In addition, the membership is reminded of the 41st Dalhousie Refresher Course which immediately precedes the Annual Meeting, and of the social events that are associated with the latter.

If it is at all possible, please attend these Meetings, have your knowledge refreshed, contribute to the affairs of your Society, and enjoy some pre-Christmas entertainment.

G. McK. Saunders, M. D.
President
Medical Society of Nova Scotia.

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**3rd Meeting of the Council**
**and**
**114th Annual Meeting**
**of**
**The Medical Society of Nova Scotia**
**(N.S. Division C.M.A.)**
**Hotel Nova Scotian, Halifax**
**November 24th & 25th, 1967**

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Please print the name of the hotel or motel in which you wish to have accommodation:

First choice..... Second choice.....

Other.....

Date of arrival:..... Expected time of arrival.....

Date of departure:.....

Room will be occupied by: Name(s).....

.....

.....

.....

Accommodation required: (please check one)

Single..... Double..... Twin..... Suite.....

Signed.....

N.B. If attending the Clinical Programme (Refresher Course) as well as the Council and Annual Meeting please indicate by checking ( ) yes, or ( ) no.

Complete and forward to:

The Executive Secretary
Medical Society of Nova Scotia
Sir Charles Tupper Medical Building
University Avenue
Halifax, N. S.

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Additional Note

The 41st Dalhousie Refresher Course (November 20 - 23 inclusive) is the Clinical Programme of the Annual Meeting of the Society.
If you are planning to attend both functions please so indicate above.
Joint Registration for both Meetings will be available at the Refresher Course.

# Medical-Legal Enquiries

## FEE FOR MEDICAL-LEGAL REPORTS

Q: I would appreciate some practical guide-lines on which to base charges for medico-legal work (research, written reports, court appearances etc.). They often seem uncollectable.

A. This appears to be a very real and wide-spread problem. In the past we have attempted to outline general principles both in the Medical Newsletter[1] and in this column.[2]

A view from the other side might be helpful; with this in mind the question has been submitted to a legal colleague who writes:

"In matters of contracts and personal service, it is always a problem to decide what is the proper charge. It depends on the seriousness and the expert knowledge which the sickness requires, and upon the financial position of the patient. No one can set any standard figure on the services performed by a doctor, but they must at no time be outlandish and can always be subject to review by a Court of law where the patient refuses to pay the sum tendered. The Court then takes into consideration the nature of the illness, the services rendered and whether or not the fee being charged is reasonable under the circumstances.

"Frequently the lawyer asks the doctor for a report of his medical services rendered and also subpoenas the doctor to attend in Court for the trial. Some doctors believe that the lawyer should pay for the report as well as for the Court attendance because he orders same and because these are separate items from medical services tendered to the patient. In many cases, however, the legal client has not even paid the lawyer and waits for the outcome of the trial. Certainly lawyers cannot be asked to be personally responsible for these services, but the general practice of barristers is to try and protect the doctor if and when a settlement cheque is received by sending him a cheque for these services as well as the medical services tendered.

"In some cases where the action is dismissed, the doctor still feels aggrieved and looks to the lawyer to pay him, but this is impossible.

"Even if the lawyer is successful and obtains a Judgment he must then tax a Bill of Costs and the Taxing Master will go over the items under the heading of "disbursements" to see if the doctor's charges are proper. Obviously, if a medical report consists of a few short sentences, he will disallow a bill of $50.00 submitted by the doctor for the medical report, and perhaps allow as taxing disbursement against the Defendant the sum of $10.00 to $15.00, and this is all that he will be paid unless the patient wants to make up the difference.

"Similarly, if a doctor appears in Court at the trial and stays there either a morning or a few hours, he certainly would not be entitled to be paid $100.00 for his attendance as an expert and the Taxing Master may cut it down depending on the amount of time spent by the doctor in Court, to an appropriate figure, and here again the amount which can be recovered from the Defendant would be the sum allowed as a proper taxation charge."

These remarks may appear to be at variance with the 1963 Schedule of Fees of The Medical Society of Nova Scotia[3] but this is not really the case.

*Section* 120 (Examination and written report-Medico-Legal) is designed to cover a complete assessment of a case for litigation purposes, **not** "a few short sentences", nor a written report of a previous examination. The last is covered in *Section 130* for which the Schedule assesses a proper charge to be $10 - $15.00. Notwithstanding this from time to time a physician submits his account for a simple letter under *Section 120* and is disgruntled when such a bill is contested.

Although the lawyer cannot be held responsible for assuring that his client pays his bills it is clearly in the interest of his case to see that no impediments are introduced. He will therefore try to avoid antagonizing the doctor unnecessarily. However, as his client has placed his affairs in his hands expecting that the lawyer will protect his interests, the lawyer may well feel duty-bound to protest a bill which he regards as totally unreasonable. We should be wise to keep this in mind when we submit accounts for our medical-legal services. □

I.M.

**References**


1. *Medical Newsletter*, The Medical Society of Nova Scotia **5** (1) : 4-5 (Mar. 1965).
2. *Medical-Legal Enquiries*, N. S. Med. Bull. **46** : 90, 1967.
3. *Schedule of Fees*, Med. Soc. N. S., 1963 pp. 8-19.

# Control of Tuberculosis*

*Despite improved methods of detection and treatment, tuberculosis remains the most common cause of death from infectious disease in the United States. The tuberculin test is an important tool in detecting infection, and drugs are the foundation of treatment.*

Each year approximately 1,800 cases of tuberculosis are first reported at death in the United States. In 1964 tuberculosis had dropped to the 20th place as a cause of death, but it is still the most common cause of death not only in the United States but also throughout the world.

Recent carefully planned studies indicate that tuberculous patients receiving modern chemotherapy rapidly become relatively non-infectious to persons in their immediate environment, even though their sputum smears and cultures remain positive. While the studies do not prove that these patients are completely noninfectious, they do justify a change in attitude about prolonged hospitalization. Thus, today tuberculosis treatment can be initiated in tuberculosis wards in general hospitals and continued in clinics outside the hospital.

The tuberculin test has become a valuable tool in tuberculosis detection, especially in the young. In populations with high incidence, X-ray surveys still have a place. Family contacts of newly discovered open cases of tuberculosis are the most productive source of new cases. Many cases are also found in X-ray surveys of inmates of jails, mental institutions, and nursing homes.

Case detection in populations of low incidence ideally should consist of an annual tuberculin test, and X-rays of those who become positive. After age 35, people should have an annual X-ray regardless, because of the additional yield of other unsuspected diseases.

The best screening tuberculin test is the Mantoux, using intermediate-strength PPD. The tine test and Heaf test are almost as reliable.

**Standard Drug Treatment**

In the treatment of tuberculosis three drugs constitute "standard chemotherapy." These are isoniazid, streptomycin, and PAS (paraminosalicylic acid). Results with regimens of all three drugs are probably no better than a regimen of streptomycin and isoniazid. A regimen of isoniazid and PAS is often chosen because drug toxicity is less with this combination than with the other two.

The arguments for an initial three-drug regimen are: (1) When patients have primary resistance to one drug, there is an advantage in the three-drug regimen because the patient's bacilli will be susceptible to at least two; (2) Rapid reversal of infectiousness has the theoretical advantage of reducing the chance of emergence of a clinically significant population of drug-resistant organisms.

In original-treatment cases, drug therapy should be continued for a minimum of 18 months. For patients who have slow reversal of infectiousness, or frequent interruptions of drug-taking, less than optimal drug selection or dosage, and sometimes, for patients with very severe disease, chemotherapy should be continued two to three years or more.

The dosage of isoniazid recommended by many authorities is 200 to 400 mg. per day. Larger doses 400 to 1,800 mg. a day, depending on body weight, are recommended by a few observers.

When streptomycin is included in the drug regimen, it is generally accepted that it should be given once daily for at least 30 days, often for 90 days, or until reversal of infectiousness by culture. This drug should be stopped at first sign of vestibular toxicity.

PAS dosage consists roughly in 200 mg. of sodium or calcium PAS per kilogram of body weight per day, or 100 to 150 mg. of acid PAS per kilogram a day, divided into two or three doses. Nonsodium containing PAS must be used in older patients who are or may be in marginal compensation of the heart.

**Retreatment Drugs**

Retreatment drug therapy consists of the use of ethionamide, pyrazinamide, ethambutol, capreomycin, kanamycin, cycloserine, viomycin, and thiacetazone (TB-1). Retreatment should always be initiated in the hospital.

In persons who have never received any of these drugs, it is relatively easy to choose two or three previously unused drugs that the patient can tolerate. Preferably only one drug used should be an antibiotic absorbed only by the parenteral route (kanamycin, viomycin, capreomycin) since combined use of these agents increases the risk of vestibular or auditory toxicity. Ethambutol and capreomycin are not yet available for general use.

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Roger S. Mitchell, M.D., *The New England Journal of Medicine*, April 13 and 20, 1967.

*Reprinted from the Abstracts of the National Tuberculosis Association, September, 1965.
Printed through cooperation Nova Scotia Tuberculosis Association.

Other forms of treatment of tuberculosis include rest, collapse and resection, but should be considered as *adjuvants to chemotherapy*. It has been established that rest is not necessary in conjunction with modern primary chemotherapy. This may be true also of retreatment chemotherapy. Rest is indicated when patients feel tired, are actively sick with fever, have constitutional symptoms or hemorrhage, or are not receiving effective chemotherapy.

The adjunctive use of corticosteroids with antituberculosis chemotherapy is common practice in tuberculous meningitis. When corticosteroids are administered to seriously ill patients, they should be continued for from two to three weeks and then gradually reduced in amount.

The principal causes of chemotherapy failure are the use of too few drugs and interruptions in drug therapy. The essential ingredient in antituberculosis chemotherapy is that drugs be taken as prescribed.

Preventive treatment is an important control measure among persons who are tuberculin positive but do not have clinical tuberculosis. Children under five years of age with a positive tuberculin reaction should be considered to have clinical tuberculosis and be so managed. Persons with a positive tuberculin reaction and inactive tuberculosis are also candidates for preventive treatment.

Preventive treatment usually consists of the use of isoniazid alone in conventional doses. Maximum benefit has been observed during the period of drug administration in trials of preventive treatment.

BCG vaccination is both effective and safe. It does not provide complete protection. Because its use is expensive and time-consuming, it must compete with other methods of control for the time and money available. In most of the United States the risk of exposure to tuberculosis has reached a level sufficiently low so that the expenditure of time and money on BCG programs is not considered as effective as expending the same amount of time and money on tuberculin testing and treating certain reactors, X-ray screening of special groups, examination of contacts of patients, and most of all thorough treatment of known cases. □

## INSTRUCTIONS TO AUTHORS

Members and others wishing to contribute to *The Bulletin* are invited to submit their material to the Offices of The Medical Society, Sir Charles Tupper Medical Building, Halifax, N.S. In general the rules laid down for the *Canadian Medical Association Journal* and published therein under the heading "Instructions to Contributors".

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