THE NOVA SCOTIA MEDICAL BULLETIN

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Focus on Communication

In this year of 1968, we celebrate the centennial of the foundation of the first Faculty of Medicine of Dalhousie University. As part of our contribution to these celebrations, the Bulletin has run, under the heading of "100 Years Ago", extracts from the minutes of some of the early meetings of that Faculty. Reviewing these minutes has been interesting, sometimes amusing, and frequently instructive.

When one contemplates the beautiful copperplate handwriting and reads the measured and leisurely phrases, one cannot help reflecting on the changes which have taken place in the written word and its usage during the past 100 years, and wonder whether we are not at present at a crisis point in the art of communication, where we are in danger of losing not only the art of writing but also of speech as a form of communication.

The illegibility of the doctor's handwriting is legendary: where once it was excused as a device to confuse the patient, it has now become a wry joke, since other doctors cannot read the histories and consultation reports made by their colleagues. Here, communication in the written form ceases, and has to be replaced by speech, one doctor seeking out another to find out precisely what he did think about Mr. So-and-so's complaints.

Writing by hand has become outdated: it is faster to type, and easier still to dictate onto a tape and have a typist transcribe our words. Yet, losing the discipline of writing down our thoughts to convey a precise meaning, much dictation that is transcribed becomes imprecise and devoid of meaning. Because of our sloppy habits of speech, where we use more words than are necessary to convey an idea, and frequently repeat ourselves, transcribed dictation may become so much verbal garbage, and the reader may tire of searching for the ideas that are hidden there. At this point also, communication ceases.

Thus it is clear that education in the art of communication should include the teaching of typing rather than writing, dictating readable sentences in addition to the acquisition of a basic vocabulary, and the learning of dictating "frameworks" rather than straightforward composition. In addition, students should have considerable practice in turning garbled transcriptions into precise readable sentences as an aid to thought. It is interesting to note that none of these skills is at present taught in our present educational system, and only the basic skills in typing are taught in most stenographic courses. As most educators and business men will recognize, the majority of stenographic help has to be put through a period of on-the-job training before any facility is acquired in the production of accurate readable transcripts.

Those who are familiar with the harried intern's record of a physical examination may be able to decipher such observations as HEENT PERLA, Glands O RS Clear to IPPA, CVS NAD etc. Nevertheless, they will be interested to learn the result of a recent innovation enabling fourth year medical students to dictate their histories and physical examination results, and have them transcribed by expert typists. Suddenly the standard 'History and Physical' becomes a joy to read, a miniature detective story which is clear and concise. This startling change is made possible by the ease of dictation, helped by the set framework required for this type of report, and enforced by the challenge to the student of having his words set out plainly for all to see and criticise. Undoubtedly, this form of practical instruction in one method of communication will stand these students in good stead in their future careers as doctors, so that many more will reach the standard of excellence at present only attained by the leaders in academic life

Rapid accurate transcription is favouring another change in the field of communication of scientific information. Formerly, Scientific Meetings relied on the presentation of papers describing methods and results, with discussion mainly directed at elucidating minor points. Subsequently, the papers were published in Medical Journals, often in amplified form, and conveying substantially more information than was possible at the Scientific Meeting. Because of the very limited amount of information that could be conveyed in the time available, there has been a recent tendency towards including an increasing number of panel discussions in these programs. Although these conveyed much more information to the audience, unless they were accurately transcribed and edited, much of this information was lost, and could not subsequently be published.

Next month, Dalhousie University will sponsor an important experiment in the communication of scientific information in the format of the Program of the Centennial Celebrations, which will take place on September 11th, 12th, and 13th, 1968. Here, there will be a minimum of prepared presentations, and the entire program will centre around panel discussions with audience participation.

Leaders in the fields of Education, Genetics, Organ Transplant, Religion and Law, drawn from fifty institutions in five countries, will act as catalysts for these discussions. Following a keynote address, the experts will adjourn to form six separate panels, each discussing a particular aspect of the subject for that day. They will participate with their audience in a search for solutions to the problems raised, and in this way not only impart information, but also generate new information. After these sessions, the chairman of each panel will join together under the chairmanship of the keynote speaker in a round table discussion of the findings of the panels.

While the findings of these panels and round table discussions will be of great interest to the audience, they will obviously have far wider implications, and may serve to channel the lines of research in these subjects among scientific workers throughout the world. It is therefore of vital importance that these discussions be adequately recorded, transcribed, edited while they are still fresh in the minds of the panellists, and brought into a form suitable for publication.

Because these discussions will be led by outstanding speakers, accurate transcription should be rendered easier, and the success of the conference assured. However, the production of an accurate recording of the proceedings of six simultaneous panels and a round table discussion daily will challenge the facilities of the Audio-Visual Department of Dalhousie University. Back-up facilities through shorthand recording are being supplied through the co-operation of the Halifax Board of Trade. The production of an accurate written record of the proceedings within a few hours of the completion of the discussions has presented a major problem, and will only be made possible through the co-operation of the IBM Corporation in supplying sophisticated electronic machinery for this purpose.

Not only will Dalhousie University be celebrating its Centennial with a major scientific event, but it will also indicate to scientists everywhere the possibilities engendered by this important method of communication. □

I.E.P.

The Medical Society of Nova Scotia

has pleasure in announcing the

APPOINTMENT

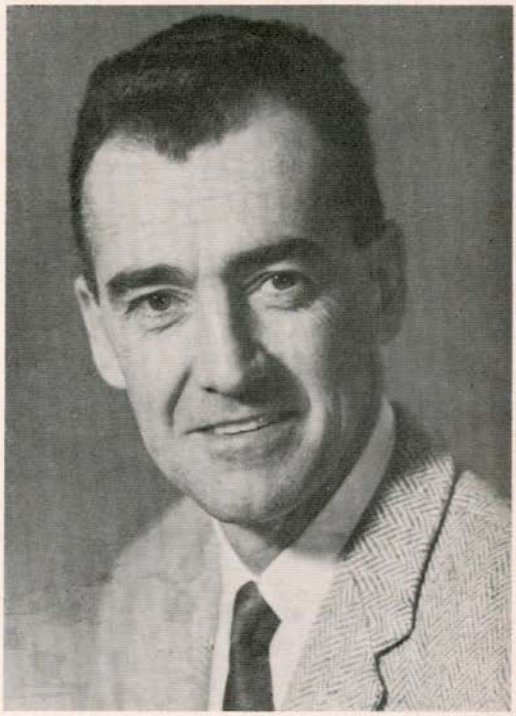
of

Mr. Douglas D. Peacocke
(LtCdr RCN Ret.)

as

EXECUTIVE SECRETARY

To The Society.



With effect from July 1st, 1968, Mr. Douglas D. Peacocke will assume his post of Executive Secretary to The Medical Society of Nova Scotia. He brings to this post a most impressive experience in personnel management and organization gained during his career in the Services: the development of the Naval Air Reserve from a handful of partially trained pilots to a five squadron organisation: liaison work with the US Navy, involving management of a number of projects concerned with equipment evaluation; and the post of Operations Officer for the aircraft carrier Bonaventure, which involved co-ordination of the training and operational employment of the carrier, its aircrafts, and associated ships, and analysis of the results of exercises. As Operations Officer at Shearwater Air Station, he was also involved in long range planning and examination of future equipment and training requirements. Later, he joined the instructional staff of the Maritime Warfare School, becoming Director of the academic Division, where he was responsible for the formulation of the annual school training programme, evaluation and up-dating of the lectures, overall administration of the courses, including planning and co-ordination of the operational exercises, and their subsequent analysis. In addition, a number of special projects were assigned to him which involved organisation of methods, equipment and personnel.

In 1967, Mr. Peacocke attended a night course at Dalhousie University on the Principles of Business Management, since re-named the Executive Development Course. This extremely up-to-date course constitutes a severe challenge even to the established business executive, and deals in depth with the principles of organisation and management, business policy, finance, production, managerial accounting, mathematics in problem solving, control and work-study: work-measurement.

Mr. Peacocke is 44, married, with nine children. Naturally, he is interested in Education, and was until recently a Director of the Dartmouth Academy. His hobbies are curling, golf, skating and swimming.

The Committee of the Medical Society which interviewed applicants for the post of Executive Secretary was most impressed with his qualifications, not the least of which are a mature outlook and a most pleasing personality. They are satisfied that he will rapidly apply sound principles of business management in the operation of the business affairs of the Society, and will ensure that the policies of the Society as determined by the membership, the Officers, and the Executive will be effectively carried out.

On behalf of the membership of The Medical Society of Nova Scotia, we welcome him to his new appointment and wish him every success. □

Halifax Infirmary Intensive Care Unit: View of Open Area

Halifax Infirmary Intensive Care Unit: Nursing Station

The Intensive Care Unit
A Review of Planning and Concepts

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Halifax, N. S.

During the past few years many hospitals have been establishing intensive care units in the hope of providing more efficient care of the critically ill. This concept of progressive patient care or intensive care is not a new one. The Obstetrical Unit, the Operating Room, the Recovery Room and the Premature Nursery are specific examples of areas in the hospital where specialized care and attention can be focused on certain problems.

The purpose of this article is to detail certain basic guidelines for the planning and organization of an intensive care unit. The information presented has been gleaned from the available literature and from our experience in the establishment of an intensive care facility at the Halifax Infirmary, where we have decided that an Intensive Care Unit does not have to be large, complicated and expensive to be a good one. There is much to be said for a small, efficiently planned and well administered unit. If the unit is too large, the temptation is to admit patients who do not really need the type of care offered in a good intensive care unit, the result being a dilution in the quality of care in the unit. The axiom should be: keep the quantity of patients down and the quality of care up to the optimum. Further, the smaller the unit the easier it will be to acquire and train a staff of qualified nurses. The key to a successful intensive care programme in any hospital is to have an adequate number of skilled nurses especially trained to provide a high calibre of nursing care. The main function of the unit is to centralize specialized services so that equipment, drugs, nursing staff, laboratory and X-ray facilities, as well as medical personnel can be directed towards the patients who need them.

The concept of an intensive care unit appears to provide the best means of maintaining constant vigilance and providing nursing care. Ideally, trained nurses are able to note minute changes in a patient's condition and thereby avoid possible complications.

The Advantages of an Intensive Care Unit.

1. CONTINUOUS OBSERVATION OF THE PATIENT. When patients are concentrated in a small area they may be observed continuously. Sudden changes in vital signs can be noted and steps taken to prevent deterioration. A nurse is never more than a few steps away and ideally the patient can be observed continuously.
2. CONTINUOUS SKILLED NURSING. All personnel are trained to care for the acutely ill patient. With increasing experience slight changes in a patient's condition can be detected.
3. CONCENTRATION OF EQUIPMENT. Bringing the patient to the specialized equipment rather than taking the equipment to the patient avoids much duplication of equipment and personnel.
4. ECONOMY TO THE HOSPITAL. Fewer instruments are required to treat more patients when both the patients and the equipment are concentrated in the one area.
5. INCREASED THERAPEUTIC SKILLS. The concentration of patients in one area makes for perfection and standardization of methods of treatment. With experience, more and more patients are saved through greater clinical knowledge and skill in the handling of these cases. For the intern and student nurse the units are a valuable source of instruction and even the most learned and most knowledgeable physician cannot help but learn more working in such a unit.
6. MEDICAL RECORDS. Progress notes and notes regarding vital signs, medications, and intake and output are more plainly and accurately recorded, thereby increasing the value and completeness of patient's records.

Planning of a Unit.

Needless expenditure and unnecessary equipment can be avoided if careful consideration is given to the needs of the individual hospital before elaborate units are designed and constructed. While it is possible to define certain principles of design, the specific circumstances of every locale will determine and modify the form and function of a particular unit. Joint planning should include at least the hospital administrator, physicians, nurses, architects and an electrical engineer. The essential nucleus should be an Intensive Care Unit Committee appointed by the Medical Staff, which is responsible for planning, formulation of policies and organization of administrative and educational duties.

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One measure of the appropriate *number of beds* for an Intensive Care Unit relates to the size of the unit to the number of beds in the hospital. Most authorities state that the number of beds in the unit should represent 3-6% of the total number of beds in the hospital. However, the number of beds required is not necessarily related directly to the size of the hospital but is more likely dependent on the types of admission to the hospital and the type of specialized service available. The maximum limit in size appears to be 12 to 15 beds, since more beds cause difficulty in providing nursing care from a single nursing station.

Generally, one may subdivide Intensive Care Units into the following main types according to their function and purpose;

A. Surgical Units.
   a. Pre-operative Management
      1. Shock
      2. Trauma
      3. Burns
   b. Post-operative Management
      1. Major Thoracic Surgery
         e.g. Pneumonectomy
      2. Major Cancer Surgery
         e.g. Abdominal Perineal Resection
      3. Major Vascular Surgery
         e.g. Aortic grafts
         Porto-Caval Shunts
         Renal transplants
      4. Major Cardiac Surgery
         e.g. Open Heart Surgery
         Heart transplants
      5. Major Neurosurgery
         e.g. Hypophysectomy

B. Medical Units.
   a. Coronary Care Units
   b. Respiratory Units
   c. Metabolic Units
      1. Diabetic coma
      2. Pheochromocytoma
      3. Renal insufficiency
      4. Fluid and electrolyte problems

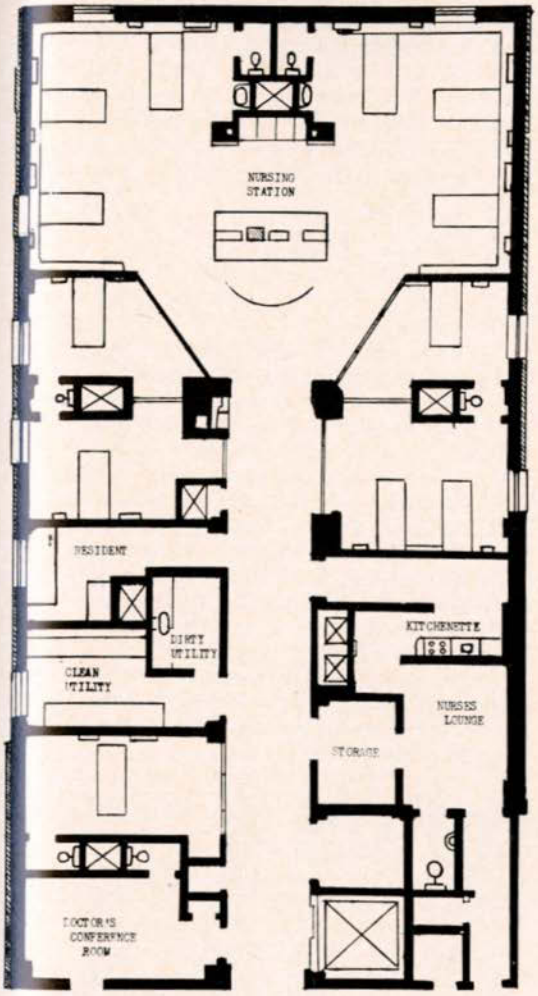
It is apparent that while larger and more specialized hospitals need a greater number of beds allocated to nursing care purposes, a different approach to the planning of intensive care facilities is justified in the smaller general hospital. The principle of having specialized units located in separate areas in large teaching hospitals is good, but this approach seems impractical for a hospital such as our own, a 500-bed general hospital serving the communities of Halifax and Dartmouth. Consequently, our Intensive Care Unit Committee decided that there would be a single unit for all services in the hospital and that a coronary care section would form part of our unit. We were in favor of integrating the coronary care beds in with the general intensive care complex for the following reasons:

1. The single unit solves the problem of providing a full-time Resident and Intern coverage in that one Resident can supervise the care of all patients on a continuous basis.
2. More nurses would be required if the coronary care unit and the general intensive care unit were separate.
3. The single unit allows for the centralization of equipment and avoids duplication of oxygen and suction outlets.
4. There is great advantage in terms of sharing equipment and skilled staff in the juxtaposition of the various forms of unit; that is Coronary care, Respiratory care and Surgical care.
5. Since patients are often afflicted with multiple problems affecting several different organ systems, nurses trained in a single unit where all types of problems are treated are more able to cope with the care of such patients and this care can be more easily focused on the patient in the single unit.

We decided to restrict the bed capacity of our unit to fit the space available. Not only would this provide more space per patient but it would also place more emphasis on the quality of patient care rather than on quantity. Thus by a combination of circumstances the bed capacity was fixed at 12 beds; six beds for general use and five beds devoted specifically to coronary care, one bed being reserved for the purpose of resuscitation in an emergency.

The *location of the Unit* in the hospital should be given careful consideration. While the unit should have its own supplies, equipment and nursing staff, it should be located where it is not isolated and ideally should be adjacent to a general medical facility. It seems reasonable to have it situated near the Operating Rooms and Recovery Rooms. The unit should be central and easily reached from other sections of the hospital especially the Emergency Department and the Admitting Room. It should be in an area that allows surplus space for storage, monitoring equipment, service and utility area, a Doctor's conference room, Resident's room, a kitchenette, Nurses' lounge and a Nursing station.

It seems that each hospital contemplating a new Intensive Care Unit is (at the present time at least) a pioneer in the search for the ideal solution to the design of a unit. This field is changing so rapidly that the hospitals cannot possibly keep pace with such dynamic changes. We determined to avoid some pitfalls of other units and profit from their experience. The fact that we had decided to have all our intensive care facilities in one area, in itself, created problems. We attempted to integrate important design principles into a plan for producing constructive alterations to an existing ward on the fourth floor of our hospital.



The floor plan (above) of the Intensive Care Unit at the Halifax Infirmary demonstrates the manner by which an existing rectangular shaped ward can be modified to make it more suitable for function of Intensive Care.

Note the central nursing station which is located only a short distance from each of the beds. Glazed walls in the enclosed cubicles permit direct visual contact with the patients. Also note the continuous counter about the perimeter of six bed ward. Storage space is provided beneath the counter, for supplies which might be urgently needed in an emergency.

In planning our Unit we tried to follow as closely as practical the following pre-requisites for good design.

1. Each patient should be in view of the nurse and conversely the nurse should be seen by the patient.
2. Positioning of the beds on the outer wall appears to be the best solution for providing the greatest visibility from the Nurses' station.
3. A centrally located nursing station is almost mandatory.
4. Blocking the field of vision between patients is desirable. This may be done either by building cubicles, using curtains, or using partitions built of a combination of metal and glass.
5. Provision should be made for future expansion.
6. A reasonable degree of peace and quiet for coronary patients is desirable.
7. Toilet facilities should be provided.
8. A counter top sink should be provided in or close to the Nurses' station.
9. There should be provision for general room illumination, convenience lighting and night time lighting. A portable examination light should be provided so that all parts of the patient's body can be illuminated.
10. To minimize equipment around the patient's bed some should be mounted on the wall and some of it recessed into the wall.
11. Provision should be made for the construction of a service panel at one side of the bed. The panel should include the following outlets:
    a. 2 oxygen outlets;
    1 air outlet;
    3. 3 suction outlets: - one for nasopharyngeal suction, one for Wagensteen suction, and one for intrathoracic suction as all these be necessary on the same patient.
    b. Electrical outlets: - Five duplex outlets each on separately grounded circuits should be located at each bedside.
    c. Wall mounts on the panel for securing suction bottles.
12. A sphygomanometer mounted on the wall in the center over the patient's head enables the nurse to take the blood pressure from either side.
13. Wall outlets should be installed for portable X-ray machines (220 volts).
14. A viewing box for X-ray plates and a blackboard for teaching purposes should be erected in some convenient location.
15. Air conditioning is almost a necessity in these units because of the various odours. The relative humidity should be maintained at 50%; the temperature at 72-75 degrees Fahrenheit. There should be air exchange at least four times per hour. The atmosphere in the unit should be maintained at a slight positive pressure relative to the outside corridor to prevent the infiltration of contaminated air. The ventilation system should be independent of the rest of the hospital.

16. Provision should be made for a "clean and soiled" utility area. Also space should be provided for linen cart storage.
17. A Resident's rest room should be included.
18. A Doctor's consultation area is desirable.
18. "A visitors' and relatives" waiting area should be included.
20. Space for lockers for the storage of Patients' clothing and personal possessions should be provided.
21. Space engineering is extremely important in ICU design. The area to be devoted to each bed in a large open room is usually from 70 to 100 sq. ft. If each bed is in a rigid walled cubicle the area needed is 100 to 160 sq. ft. These are strictly minimum requirements and it would of course be desirable to have even more space available.

The total area of the unit generally is about 2½ to 3 times the area allotted for beds alone. Beds in the unit require a minimum of 9 feet of end wall space to allow adequate area for equipment, outlets, and working space for nurses. The distance between the nursing station and the patient should be short as possible. Floor space around each cubicle should be ample for the positioning of bulky emergency equipment such as respirators, defibrillators, pace makers and portable X-ray machines. Partitions between cubicles can be such that they can be dis-assembled, leaving a single open area if necessary.

Monitoring Systems

The patients most in need of monitoring in the Unit are the acute coronary cases. It is in this particular group that monitoring of the electrocardiograph and pulse has proved most rewarding. The mortality rate from myocardial infarction is 30 per cent. Since some form of cardiac arrhythmia occurs in 80% of all cases of myocardial infarction and approximately 50% of the deaths are due to the development of some form of cardiac arrhythmia, about 15% of the patients who have an acute coronary attack can potentially be saved by the early detection and treatment of these arrythmias. It is considered ideal to monitor the ECG of all coronary patients during the first five days of their illness in the hope of detecting and treating any arrhythmias which develop.

Since the field of electronic monitoring is progressing rapidly and most physicians are uncertain as to the most effective approach to patient monitoring, our unit was constructed with large conduits in the walls so that wiring of any type can be installed between the nursing station and each bed. This arrangement allows bedside monitoring to be installed and will also allow for the addition of any monitoring system which may prove more desirable in the future.

A monitor cannot replace an intelligent and observant nurse. Electrical monitoring should be used to supplement nursing observation - not to replace it.

Some of the parameters which can be monitored in an intensive care unit are listed as follows in the order of preference.

1. Blood pressure
2. Pulse rate
3. Electrocardiogram
4. Direct arterial pressure
5. Central Venous pressure
6. Body temperature
7. Tissue oxygen
8. Blood pH, PCo2, Standard bicarbonate
9. Cardiac Output

In addition to the items already covered, the following special equipment should be readily available at all times, the numbers of any one item of equipment varying with the size and experience of the Unit: -

1. A resuscitation cart for emergency use. On the cart should be: - oral pharyngeal airways; A Brook airway for mouth-to-mouth artificial respiration; endotracheal tubes and laryngoscope, an Ambu respirator bag, as well as respiratory and cardiac stimulants. Each nurse should be trained in the use of the Brooke airway and the effective technique for external cardiac message. For the latter, a firm piece of plywood for quick placement under the patient's mattress increases the efficiency of the massage.
2. Bronchoscopy and tracheotomy trays should be standardized. A large number of suction catheters will be required because with each suction through the tracheotomy tube a sterile catheter must be used to avoid infection.
3. Equipment for cardiac defibrillation and pacemaking.
4. Respirators equipped with proper humidifying systems.
5. Hypothermia apparatus.
6. Stock drugs consisting of many routinely used drugs and also drugs that might be used in the Recovery Room or Emergency departments. Careful selection of equipment is necessary to avoid over-stocking. A minimum of floating equipment should be in the unit to conserve floor space and diminish cross infection. Overhead intravenous tracks should be used.

Beds

Ideally, the bed should be a cross between a recovery room stretcher and an ordinary ward bed. It should be easily moved and have large anti-static casters or wheels. The head and foot boards should be removable as well as the sides. Sideboards should move vertically up and down instead of swinging out. The sides should not interfere with the handling of the patient or interfere with the making of the bed. The removable headboard is extremely important for easy and quick access for the purpose of endo-

tracheal intubation, pharyngeal suction, tracheotomy care and the use of respirators. The bed must be capable of being placed quickly in the Trendelenburg position. The ideal width is about 34 inches.

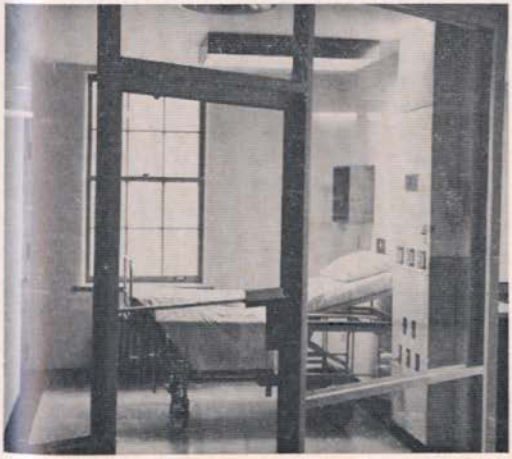
Infected Cases

The infected or potentially infected case can present a problem. Cross-contamination from one case to another must be avoided. Some hospitals have solved this problem by constructing isolation rooms in their units where such cases can be isolated from the other patients. Others have circumvented the problem by making it a matter of policy not to admit infected cases to their Intensive Care Unit.

* * *

It seemed reasonable to us, all these considerations in mind, to place the coronary patients in single rooms where privacy and quiet could be assured them, the surgical and respiratory patients being located in the six-bed ward at the end of the unit immediately adjacent to the nursing station. The rooms available on the remainder of the ward provided additional space for the inclusion of a clean and dirty utility area, locker space for patient's clothing, Resident's room, a Doctor's conference room and a Nurses' lounge with kitchenette.

A central monitoring console which included an eight channel oscilloscope is located at the Nursing Station. The electrocardiographic patterns of eight patients can be followed simultaneously; an alarm system will alert the nurse to any alteration in the rate and rhythm of the heart.



A. Coronary Care Cubicle.

Realizing the need for extensive storage facilities in the Unit we arranged for the planning of cupboard space about the perimeter of the ward. Equipment often needed at the bedside could thus be stored as near as possible to the patient. A continuous counter was installed around the perimeter of the main six bed ward. The counter is 30 inches in height and extends behind each bed. Under this counter (except behind each bed) are the storage cabinets; beside each bed is a table which can be moved around the bed when in use, otherwise being pushed back in place to form part of the continuous counter.

A utility panel was designed for each bed. This upright panel is recessed into the wall and counter on one side of each bed. It provides space for two oxygen, one air and three suction outlets. Two duplex electrical outlets are located on the lower part of the panel. Brackets for suction and drainage bottles are also located on the lower portion of the panel; the fact that the panel is recessed should serve to protect the bottles from accidental breakage.

B. General Intensive Care Bed.

Our plans provided for a centrally located nursing station which has the following functions: -

1. Observation of the patients.
2. Charting and recording of the patients' vital signs.
3. Preparation of drugs and special procedure trays.
4. A location for the central monitoring console.

Our plans provided also for the installation of a modern and up to date air-conditioning system. This system accounted for approximately one-third of the cost of the unit.

Policies

The experience of most well established intensive care units has demonstrated that the success or failure of the Intensive Care concept is directly related to the quality and enforcement of the written policies of the Unit. Units with well-written, enforceable policies seemed to have fewer operational problems and were consequently well utilized.

The policies formulated by our Intensive Care Unit Committee were based on the suggestions and rules from hospitals visited during our planning phase. However, these policies have been specifically tailored to circumstances at the Halifax Infirmary and would not necessarily be applicable in other hospitals.

The purpose of our Unit is to provide concentrated nursing care for critically or seriously ill patients who require close and frequent, if not constant, nursing observation. The need for this nursing care, rather than the diagnosis, will determine the patient's eligibility for admission to the Unit.

The policies for a unit should establish specific solutions to the following matters: -

1. The responsibility for patient care. It certainly should be established in writing which person or persons will be in charge of directing medical therapy.
2. The responsibility for the nursing care of the patients. This is usually the responsibility of the Department of Nursing.
3. The criteria for admission, and admission procedure to the Unit.
4. Discharge procedure and who is to make decision as to when a patient is ready for discharge.
5. Who will be responsible for writing orders? In our unit in an effort to reduce confusion, one person, probably the Resident, will be assigned the task of writing the orders in the order book.
6. Visiting regulations.

The Intensive Care Unit Committee will formulate and alter policy for the unit and will pass judgment on these matters.

Nurses for the Intensive Care Unit

The Intensive Care Unit Committee considered carefully the many facets of the provision of good nursing. It was the duty of the committee to insure that continuous nursing coverage be obtained and be properly trained.

1. How many nurses would be needed?
2. Should we send nurses away to other centres for training or should we attempt to train them ourselves?
3. What were the attributes of an ideal Intensive Care Nurse?

It proved difficult to estimate the required number of nurses. Obviously the need would fluctuate from day to day and from week to week depending on the occupancy or demand for services. Ideally there should be one nurse per patient for three eight hour shifts. To run our unit at full occupancy would require a total of (11 x 3) thirty-three nurses. Additional nurses would be required to allow for the regular nurses to have days off and holidays. We considered that it would be best to open our unit gradually, permitting us to begin operation with a nucleus staff of six nurses who would then help "on the job" instruction of the remainder of the required nurses.

We also decided that our nurses could be trained in our own hospital because we had the knowledge and the competent instructors to provide a well balanced course in Intensive Care Nursing. In addition the Head Nurse was sent on a tour of intensive care facilities in Montreal and Toronto. She also spent several weeks in our Operating Room where she assisted the anaesthetists, learning the techniques of venepuncture, airway control, endotracheal intubation and the methods of administering intermittent positive pressure ventilation. She also observed patients in the Recovery Room during their recovery from anaesthesia and thus she gained some experience in the handling of the unconscious patient. As a result, during the development of our unit, her experience and suggestions were extremely helpful to us.

What should be looked for when selecting nurses for work in an Intensive Care Unit? They should be able to carry out their duties with quiet efficiency and should be able to control their emotions. The nurse should be able to tolerate stress, act effectively and use judgment in emergencies. She should have good powers of observation and possess knowledge of the basic needs of people.

On March the 4th, 1968, a Course for Intensive Care Nurses was inaugurated at the Victoria General Hospital in Halifax. The course, lasting approximately four weeks, was designed to introduce nurses to all aspects of intensive care nursing. This course will be repeated four times each year and will be open to any Graduate Nurse wishing to take training in this field. In the future, the Halifax Infirmary will assist in the presentation of this course.

Several regional hospitals in Nova Scotia now have well designed intensive care facilities which are not at present utilized because of the lack of trained medical and nursing personnel. It is hoped that the course will help to relieve this shortage. These units are certainly necessary if every patient in Nova Scotia is to have equal opportunity to receive the benefits of modern medical technology.

It would be even more ideal if we could entice some of the General Practitioners now on the staffs of regional hospitals, to take advantage of the opportunity themselves, to learn new principles of the management of the critically ill patient and also learn the proper use of their electronic monitoring equipment.

The Role of the Anaesthetist in the Intensive Care Unit

The anaesthetist's knowledge of internal medicine, drug-action, intravenous therapy, fluid and electrolyte balance, respiratory physiology, the surgical management of patients, acid-base disturbances and electronic monitoring makes him uniquely equipped to offer advice on problems related to the care of seriously ill patients. He can thus be helpful during the planning and organization of the intensive care unit. He can give valuable suggestions as to suitable monitoring equipment. He can also be of assistance in the instruction of personnel in the unit especially in such matters as the maintenance of a patent airway in unconscious pa-

tients, providing adequate ventilation and the proper use of mechanical respirators.

In this particular role, the anaesthetist is becoming more and more involved in activities which take him away from his main base of activity, the operating room. Thus, even though there is an increasing shortage of anaesthetists the specialist in anaesthesia is being required to spend more and more time outside of the operating room. However, his role in intensive care increases the scope of the speciality and makes it more interesting and challenging to medical students.

Conclusion.

The Intensive Care Unit is being accepted as a more effective way of treating the critically ill patients admitted to the average general hospital.

The close liaison in our Intensive Care Unit between the medical and surgical specialist should break down the traditional arbitrary separation of the two services and our unit should be one area where no such distinction exists. We hope that it will encourage our staff members to be doctors first and specialists secondarily.

An active and responsible Intensive Care Unit Committee is essential both in the planning and in the operation of the unit.

The most important ingredient in any Intensive Care Unit is the quality of the nursing care. This is more important than the most sophisticated electronic monitoring devices.

The problems of design in regard to the maximum utilization of space have yet to be solved. There is a need for greater study of the problems and more co-operation between the medical practitioner, the architect, the electrical engineer and the hospital administrators. □

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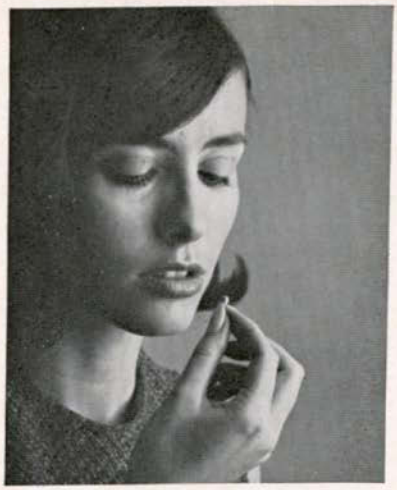

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The Work of the Hospital Tissue Committee In A 300 Bed Hospital

G. MacL. Moffatt, MD.

Fredericton, N.B.

The Medical Literature, voluminous as it is, contains little if any information outlining the work of a Hospital Tissue Committee. This dearth of information prompts this description of the Tissue Committee in the Victoria Public Hospital, Fredericton, N.B. The role played by Tissue Committees varies widely from hospital to hospital. Actually, this is not surprising nor is it necessarily a bad thing. Tissue Committees are not, and should not be static. They develop and change with advances in surgery, as new surgeons join the hospital staff and as the members of the Tissue Committee change from year to year.

As recommended by the Canadian Council On Hospital Accreditation, the Tissue Committee of the Victoria Public Hospital, Fredericton, consists of two surgeons, a gynecologist, a pathologist and an internist[2(b)]. Like any similar committee of six members, interest is sustained and the bulk of work is done by two or three members.

Method of Review

The Operating Room Supervisor provides the pathologist with a list of the operations performed each day. The list includes the patient's name, the preoperative diagnosis and the name of the surgeon. The pathologist notes any operations performed in which no tissue is submitted. The pathologist and Chairman of the Tissue Committee review the tissue reports each month. When normal tissue is removed the patient's chart is reviewed by the Committee. As a rule 10 to 16 charts are chosen for review from approximately 200 - 300 operations each month. Members of the Tissue Committee review these charts and an unanimous opinion by the Committee is required before an operation is designated as "unwarranted". When an operation has been classed "unwarranted", the surgeon is informed that the Tissue Committee considered the operation unwarranted and he is asked to be prepared to discuss the case at the next monthly meeting of the Hospital Staff. At the next meeting the case is presented by the Chairman of the Tissue Committee. The names of the patient and the surgeon are withheld. The surgeon is free to comment, or if he wishes, may allow the case to be presented without comment. Until two years ago, it was our practice to name the surgeon concerned at the monthly meetings when the chart was presented, but we soon found that the work of the Tissue Committee proceeded as effectively and with much less friction if the name of the surgeon was withheld.

If, in a particular month, the pathologist encounters a large number of "normal" appendectomies, the surgeon on the Tissue Committee reviews the charts for that month. If during another month a trend develops towards a larger number of "normal" uteri in the pathological material, the gynecologist on the committee reviews the charts.

In our experience at the Victoria Public Hospital the specimens chosen for study are chiefly those of the general surgeon and the gynecologist, that is, appendectomies and hysterectomies seem to be the operations which require the most careful surveillance.

Criteria for Operation

We have on file a "soul-searching study" done by a surgeon on our committee in which the reasons for performing an appendectomy were examined. For those of us who are not surgeons, this provides a fairly good guide to the proper indications for this procedure. Three indications for appendectomy are accepted as unequivocal and three more which may be equivocal. The unequivocal indications are:

(1) Acute appendicitis.
(2) Incidental appendectomy at a time when the abdomen is opened for another procedure.
(3) Mistaken diagnosis.

Equivocal reasons for an appendectomy are:

(1) Economic gain.
(2) Pressure from the patient's family or referring doctor that an appendectomy be done. In these cases the symptoms are not always clear cut although the patient may have considerable pain. The surgeon is often reasonably sure that the symptoms are not caused by an acute appendicitis but in many cases he cannot say definitely that the patient does not have an acute inflammation of the appendix. In many such instances, a period of observation would clarify the situation but because of outside pressure this period is not observed.
(3) The child who has recurrent abdominal pain which is not severe, nor of long duration, usually accompanied by anorexia but no vomiting. On examination there

may be some vague tenderness in the right lower quadrant but this is not marked. There may be loss of time from school. The family feels considerable anguish and uncertainty. Generally speaking the operation is not warranted in these cases.

Not infrequently an appendix removed during an elective intra-abdominal operation is found to show acute or subacute inflammation[1]. There is a tendency on the part of some observers to belittle the work of Tissue Committees on the strength of this one finding.

With respect to hysterectomy, we have a few arbitrary rules. For example, a uterus removed from a woman over the age of 35 years usually need not be considered for review. However, a normal uterus which has been removed from a patient under the age of 35 years is carefully reviewed.

The problems of the Tissue Committee are not confined to appendices and uteri. We have had no occasion, although possibly we should, to study specimens submitted to the pathologist by the orthopedic surgeons, the urologist, or the otolaryngologist. As yet we have established no criteria to guide us in determining when a tonsillectomy is warranted.

Tissue Committee Reports

Approximately every six months the Tissue Committee presents a brief summary of its activities to the Hospital Staff. In our opinion this is most important because trends of surgical practice can be noted and it promotes a discussion of principles of surgery rather than merely discussion of specific cases.

Examples of such summaries that are taken verbatim from the Tissue Committee files follow:

"An occasional gallbladder is received in which subsequent review of the chart showed that the cholecystogram was normal, yet the surgeon proceeded with a cholecystectomy. The Tissue Committee does not agree that because the patient states that he or she feels better shortly after a cholecystectomy that the operation was warranted[3]."

"With respect to surgical specimens obtained from the parotid gland, the great majority of these specimens originate with one general surgeon. He submitted a wide variety of lesions: sialo-adenitis, sialo-lithasis, papillary cystadenoma lymphomatosum (Warton's Tumour), mixed tumour and hemangioma of the parotid. The relatively large number of parotid lesions coming from one surgeon reflects, no doubt, his interest and ability in diagnosing these parotid lesions".

"The decrease in the number of cases required for review is encouraging. The Tissue Committee appreciates the co-operation of the surgical staff. . . . . ".

"We note that many more needle biopsies of the prostate are being done and many of these are positive for carcinoma."

"An interesting biopsy specimen was received, the first in our hospital to date and done within the past month, a biopsy of the iris. . . . . ".

"A photomicrograph is shown which demonstrated the invasive and inflammatory reaction which can, on occasion, occur in an appendix invested with pin worms. . . . ".

"The Tissue Committee is able to report that new Mittler electric scales are available in the cutting room of the Pathology Department. All tissues can now be quickly and accurately weighed".

"The Tissue Committee is active and useful. In future it is suggested that:

(1) The Committee avoid complacency.
(2) Discussion of cases at Staff Meetings remain objective.
(3) If a case or chart is referred by the Tissue Committee it is hoped that the surgeon involved will familiarize himself with the case and be willing to discuss it at the Staff Meeting.

"In the last month eight normal appendices were submitted to the pathologist which were described preoperatively as acute or sub-acute. In some cases the histories were very poorly documented, and little effort was made to arrive at a firm diagnosis. This may be the beginning of the trend back to more frequent normal appendices as shown statistically three or four years ago.

Occasionally in his operative report a surgeon will describe a lesion as inoperable carcinoma, yet the biopsy received is such that the pathologist is unable to confirm the presence of cancer. The tissue removed for the biopsy may not have included the disease process or it may show only a low grade inflammatory process. Using the cryostat to prepare sections, which provides a quick frozen section, our pathologist can now report his findings within minutes. It is suggested that every effort be made to obtain an adequate biopsy if it can be done without endangering life or increasing morbidity. If there is any doubt that the biopsy may not be adequate, the pathologist should be asked for an opinion on the basis of a quick frozen section before the incision is closed.

The Tissue Committee suggested that every effort be made to prevent blood held in the blood bank from becoming outdated. It therefore recommended:

(a) Requisitioned blood, if not used within 48 hours, may be given to another patient.
(b) Surgeons instruct the operating nurse to call the laboratory after an operation is completed, if it be found requisitioned blood is not needed[2(a)].

Discussion:

It should not be supposed that the principle or only function of the Tissue Committee at the Victoria Public Hospital is one of discipline. If this were so, I for one would have resigned after the first meeting. The strength of the Tissue Committee and its success is due to the fact that its work is one of continuing education. An opportunity is provided each month for the members of the Tissue Committee to see gross and microscopic specimens. Many interesting specimens would not be presented to the staff if it were not for the Tissue Committee. As the tissues are reviewed each month the clinician frequently becomes interested in a particular tissue which the pathologist considers prosaic or the pathologist will stimulate the clinician's interest in a specimen, which he would otherwise overlook. For instance, within the last year such interesting lesions were encountered as an adrenal rest in an inguinal hernia; pigmented villo-nodular synovitis; sarcoid of the breast; lymphoma of cecum simulating carcinoma of the cecum; various types of carcinoma of the lung—squamous, alveolar, and carcinoma developing in an infarction; biopsy of the conjunctiva showing a rheumatoid nodule, and so on. Each member of the committee has an excellent opportunity to see a variety of diseases which are peculiar to other specialties. Since the Tissue Committee has become active many more gross and microscopic specimens are shown at our Clinic Meetings and at our Monthly Staff Meetings.

Summary:

In every hospital a Tissue Committee has an important role to play in promoting better medical care for the patients and continuing education for the hospital staff.

The work of a Tissue Committee may not advance the frontiers of the medical science but it certainly widens the Physician's knowledge and understanding of branches of medicine other than his own. □

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One Hundred Years of Medical Education at Dalhousie

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The calendar of Dalhousie University states that this institution was established in 1818, and the Faculty of Medicine in 1868. However, history is never quite as simple and straightforward as the text books suggest. In this respect it resembles medicine. Both become more complex, and sometimes more controversial, as one delves into them more deeply.

Even such a simple fact as the date of founding of Dalhousie University is not undisputed. An article published in the Dalhousie Gazette in 1903 gives the arguments for and against nine different dates ranging from 1813 to 1863. It raises the very interesting philosophical question as to what incident or episode is to be considered as the true "beginning" of a university or a faculty of medicine.

During the war of 1812 to 1814 British troops stationed in Halifax invaded the State of Maine and collected customs duties at the port of Castine. In 1817 Lord Dalhousie, Governor of Nova Scotia, proposed that a college be established with a major portion of this "Castine Fund", and obtained the approval of the Legislative Council. In 1818 the Prince Regent approved this proposal on behalf of the British Government. This is usually taken as the crucial date which represents the "founding" of Dalhousie University. But within the next few years there occurred the laying of the corner-stone of the first building, and the opening of the first building, which was used as a high school for some years. Then came the appointment of the first president of the University and the first true university classes. There was a long lapse before the second president was appointed. Dalhousie was then reorganized and became continuously operative as a university only after 1863. The writer of the 1903 article listed nine possible dates ranging from 1813 to 1863, to any of which one might ascribe the true beginning of Dalhousie University.

The Medical School had a shorter initial period of gestation of four years, 1864 to 1868. However, the University has not operated a faculty of medicine continuously for 100 years. We are celebrating in 1968 the centennial of an *event*—the establishment of the first Faculty of Medicine of Dalhousie. There were two periods when the continuity of medical education was broken, 1873—1875 and 1885—1887. Furthermore, although Dalhousie University established the Faculty in 1868. it later became the Halifax Medical College from 1875 to 1911, with a rather variable and ill-defined affiliation with Dalhousie. The present Faculty has operated continuously only since 1911.

In 1864 the Board of Governors of the University suggested the establishment of a faculty of medicine. The Honorable Joseph Howe moved a resolution, seconded by Dr. Avery, that "the Secretary communicate with the Medical Society and enquire if they would be willing to co-operate with the Board in establishing a faculty of medicine."

The Halifax Medical Society was not enthusiastic about the proposed Medical Faculty for two very good reasons—the lack of hospital facilities for clinical teaching, and the illegality of obtaining bodies for teaching anatomy.

Halifax had a hospital building at that time, but it was closed. There was also a poor house which had been in operation for many years, located near the present site of the Halifax Memorial Library. This was an institution for paupers, the mentally ill, and, on occasion, for the isolation of patients with epidemic diseases, or the incarceration of drunks. It was commonly called the Bedlam. In 1859 the City had opened a more modern active treatment hospital on the South Common. This building, later enlarged and several times remodelled, is still standing as a part of the Out-Patient Building of the Victoria General Hospital. Not long after the City Hospital was opened, the City fathers decided it was too expensive a luxury to maintain and they closed it. One rumor, not confirmed by historical records, is that the Militia stabled their horses in it for a period.

The physicians of the time were well advised to insist upon legal approval for dissection as well as a modern hospital. The grave-robbing which was an essential, but disgraceful, element in the operation of most medical schools was fortunately giving way to a legal arrangement by which unclaimed bodies could be provided to the Anatomy Department.

The Board of Governors apparently accepted the advice of the doctors in 1864, but obviously some of these doctors also felt strongly enough on the matter that they worked toward a solution of these two problems—and with complete success. It was no doubt helpful that the Honourable Dr. Charles Tupper was Premier from 1864 to 1867. An Anatomy Act was passed by the Legislature in 1868, and in the same year a joint plan was agreed upon for the reopening and financing of the hospital by the City of Halifax and the Province of Nova Scotia. The Provincial and City Hospital then became the main teaching center of the new Faculty. This was planned during 1867 but was not approved by the Board of Governors until early in 1868. Sir Charles Tupper must have been an unusually active man to have participated in the same year as a Father of Confederation, the first President of the Canadian Medical Association, and one of the leading spirits in the organization of this Faculty of Medicine.

The 'minute book' of the Faculty of Medicine records that the first meeting of the "Faculty of Medicine" was held on December 10th, 1867. There was a second meeting on December 13th, and still another on December 27th. All are clearly stated to be meetings of the Medical Faculty, and they were held in 1867. However, on February 3rd, 1868, it was reported to this group that the Board of Governors of Dalhousie University had not accepted the original proposal that this self-selected group constitute the Faculty of Medicine of Dalhousie. Another meeting was held on February 10th at which the "Dean" reported as follows:

> "In communication with the Chief Justice (who was also Chairman of the Board) the Dean was informed that the Faculty would have to be modified before acceptance by the Board, owing to various causes of which personal objections were not one."

The Dean further noted that he had had "outside conversation" with members of the Faculty, and as a result two had volunteered to send their resignations "should it favor the success of the project." This drastic surgery did indeed ensure acceptance of the plan. Nevertheless, if the medical profession was somewhat less than enthusiastic in their reception of the proposal made by the Board of Governors in 1864, it cannot be said that the Board was any more enthusiastic about the proposal of the physicians in 1868. The minute of the Board of Governors reads:

> "The Board did not feel justified in refusing the offer of the gentlemen who proposed to form a medical faculty in connection with Dalhousie University, and the faculty being ready and desirous to receive students in the ensuing spring, the Board saw no sufficient reason for postponing further action in the matter."

The first class of 14 began their studies in 1868 in the original Dalhousie College located on the Grand Parade, where the Halifax City Hall now stands. There were some practical problems for the student body as a whole as well as the medical class, illustrated by the following quotation from an article in the historical number of the Dalhousie Gazette of January, 1903. In commenting on the decade, 1863 to 1873, the author said:

> "As with all new institutions there was more or less of experiment. There was an evening class the first year, but not later. A summer session was begun in '65, but was soon discontinued. One experiment that proved permanent was the organization in 1868 of a Faculty of Medicine, with volunteer instructors from the city physicians. Its work extended into summer; the dissecting room was in the attic, and a cadaver, after a month of heat was!!!!"

It was first intended that the new Faculty of Medicine would provide only "the primary subjects," with the students transferring for their final clinical years to McGill, Harvard, or the College of Physicians and Surgeons of New York, which had agreed to accept them. But in 1870 it was decided to continue with the full course for the students already enrolled, and the first group of five graduated in 1872.

The matter of government support of universities in Nova Scotia would in itself require a long article. Suffice to say that it has been a controversial and confused subject for more than a hundred years. The new Dalhousie Faculty of Medicine was dependent wholly on the modest tuition fees which were in fact inadequate to cover the overhead expenses, although the whole teaching staff served without remuneration. By 1873 the University was forced, for financial reasons, to discontinue the teaching of medicine. But the volunteer medical teachers showed their determination as well as their love of teaching by establishing the Halifax Medical College in 1875.

Unlike the Nova Scotia universities, which were either frankly sectarian or accused of being so, the Halifax Medical College apparently was considered sufficiently pure—if not godly—that it did qualify for government support. A grant of $800 per year was made to the new school. Most medical educators of today would consider that the severance of university ties for such a small sum would be equivalent to Esau's surrender of his birthright for a mess of pottage. But it is not at all clear that the new school surrendered very much at that time. It still retained most of its ties with Dalhousie in fact, if not in law. The same volunteer doctors continued to teach without remuneration. In fact, when there was a deficit, they dug into their own pockets and balanced the books. Students in those days entered directly into a medical school from high school without pre-

medical study at a university. Dalhousie continued to provide tuition in physics, chemistry and other subjects in the first years as they had for their own earlier Faculty of Medicine. The Halifax Medical College was described as being "affiliated" with Dalhousie in 1885, and another report states that it was "fully affiliated" after 1889. Just what these terms meant at the time is not known. Since the same volunteer teachers served the Faculty of Medicine from 1868 to 1873, and the Halifax Medical College from 1875 until, and after, its "affiliation," it is perhaps not too great a strain on historic accuracy to consider the whole effort as under Dalhousie. On the other hand, it might be argued that even later, when nominally under Dalhousie auspices, it was primarily a proprietary medical school—operated by a volunteer staff of doctors with little or no financial aid from the University.

At the end of ten years the Halifax Medical College could regard itself as a "going concern" and an affiliation with Dalhousie promised an even brighter future. However, a serious storm arose within the Provincial and City Hospital. A much-envied post was available each year for one or more graduates as resident house surgeon. The candidates had a special examination by the Visiting Staff who were for the most part Faculty members. Two candidates sat the examination in 1885. Both passed, but one with much higher marks than the other. The candidate whose home was in Halifax, although the lower in standing, was given the post by the Hospital Board of Management. The medical staff insisted that the better candidate have the post, and when the Board stood firm on its right to decide, the medical staff resigned. By thus cutting itself off from a source of clinical teaching, the Faculty found it also necessary to close the Halifax Medical College. But principles came first, and not for the last time arose the cry of "No interference with Medicine by Government or Hospital Boards."

As a result of this fight of 1885, the Provincial Government took over the hospital completely and in 1887 renamed it the Victoria General Hospital in honor of the Queen's Golden Jubilee.

One side effect of this establishment of a provincially-financed general hospital has been of profound benefit to Dalhousie Medical School. It is not generally recognized that the Victoria General is one of only two provincially financed general hospitals in Canada, the other being the St. John's General of Newfoundland. As other hospitals were established in Nova Scotia, there naturally grew up a flow of referred cases to the provincial hospital affiliated with the Medical School. There was never any financial barrier as was the case in many city-owned hospitals throughout Canada. Even when Halifax was a very small city, the clinical experience available to medical students was much better than might be expected in a city hospital of comparable size. Today, about 40 per cent of the patients are the more difficult diagnostic or treatment problems from the province and 60 per cent are the less serious cases from the Halifax-Dartmouth area and suburbs. From the standpoint of teaching and of epidemiological research, this system of provincial referral is very valuable. And it grew out of a stormy episode eighty years ago which, without anyone planning it, resulted in a modern system of integrated hospital services for this province and a unique center for clinical training in Halifax.

The next major event in medical education in Halifax, and without question the greatest milestone in the whole of American medical education, was the Flexner Survey of 1910. Many medical doctors were still being trained as apprentices less than one hundred years ago. The neophyte was a sort of servant-student. He curried the doctor's horse and delivered his medicines, as well as studying the art and science of medicine, chiefly the art. During the nineteenth century, conscientious educators recognized the need for laboratory exercises including dissection, and for clinical observation at the bedside, as well as lectures. However, many less ethical or less discerning doctors opened medical schools where only lectures were given and the fees of the students paid the lecturers. These were "proprietary" medical schools. There were few entrance requirements, and at the other end of the scale few licensing requirements. A course might be as short as twenty weeks. There were 137 medical schools in the U. S. in 1910 and only 66 survived the Flexner Survey. In fact, there had been 460 so-called medical schools in the U. S. during the nineteenth century.

Abraham Flexner conducted the survey of medical schools in the U. S. and Canada for the Carnegie Foundation. His report was a "block-buster." Only a few strong medical schools withstood its blast. Dalhousie—or in fact the Halifax Medical College—received a rude shaking. It did not have the worst report in the country, but it was anything but complimentary. The result was a complete reorganization. The Medical School went through its third change. Once again it became a Faculty of Dalhousie. Full-time pre-clinical teachers were appointed and strict entrance requirements were laid down.

World War I, from 1914 to 1918, created a slowdown in the progress of the new Faculty, but in the early 1920's the Carnegie and Rockefeller Foundations provided a substantial endowment. The Dalhousie Public Health Clinic and the Medical Sciences Building were built and the Provincial Government enlarged the Pathology Institute to include teaching facilities in pathology and bacteriology. Dalhousie Medical School shortly obtained its accredation as a Grade A medical school. Its status since then has not been in doubt, but its road has often—perhaps always—been a steep and rough one.

During the whole period of life of the first Faculty and of the Halifax Medical College the Dean

was Dr. A. P. Reid and the President of the College was Dr. W. J. Almon, a name well-known in Halifax medicine, three generations of this family having practiced here.

On the reorganization of the Faculty in 1911, no one was given the title of Dean, but the undoubted leader of the Faculty was Dr. A. W. H. Lindsay, Professor of Anatomy, who was secretary until 1915. Dr. John Stewart served as Dean from 1919 to 1932, ably assisted by Dr. W. H. Hattie, Professor of Preventive Medicine, who was Assistant Dean in title but carried most of the administrative responsibility while Dr. Stewart continued his career in surgery. Dr. Stewart was a Nova Scotian educated in Edinburgh. He was houseman to Dr. Joseph Lister, later Lord Lister, when the pioneer clinical studies on the control of wound infection were carried out.

After Dr. John Stewart and Dr. Hattie, Dr. H. G. Grant was appointed Dean and Professor of Preventive Medicine. He had had a distinguished career in public health in the United States, coming to Dalhousie from the post of Commissioner of Health for the State of Virginia. During the period of 1933 to 1954 he and the Faculty had to contend first with the economic problems of the Great Depression, when the University had to consider seriously whether both the Faculties of Medicine and Dentistry might have to be closed. In fact, the enrolment of students from the Atlantic Provinces fell off so seriously that about half of the student body was from other areas, chiefly New York.

Before recovery from the Depression was complete, World War II created new problems of accelerated courses, the loss of most young staff members to the Armed Services and a tremendous increase in the workload of all practitioners, as Halifax became the famous "Eastern Canadian Port." The influx of veterans followed the War. The Medical School was able to cope with these problems, difficult as they were. In 1940 the first government aid was provided by Nova Scotia, and by 1947 all of the Maritime Provinces and Newfoundland were assisting the two faculties of Medicine and Dentistry.

Nothing is said of the history since 1954, which is left to a more objective evaluation by others. Suffice to say that Dalhousie University's Faculty of Medicine has continued to serve as the only center of undergraduate medical education for the four Atlantic Provinces and has developed also as a major center of postgraduate medical education in almost all of the clinical specialties. It is rapidly taking its place also as a center of medical research and graduate education in the medical sciences. □

MEDICAL-LEGAL ENQUIRIES

IAN MAXWELL, M.B., Ch.B.

LEGISLATION REGARDING ABORTION (continued)

Leading members of the Medical and Legal professions who have served recently on local medical legal panels discussing revision of the current laws on abortion have been asked to answer two questions:

A) *What are your comments concerning the recommendations by the Canadian Bar Association and the Canadian Medical Association with respect to legalizing abortions?*

B) *What changes would you recommend yourself?*

LAST MONTH WE PUBLISHED ANSWERS RECEIVED FROM ONE OF THE PANELISTS. THIS MONTH WE ARE PUBLISHING FIVE MORE.

Malachi C. Jones, LL.B.

Asst. Deputy Attorney General for Nova Scotia, Lecturer in Criminal Law and Director of Legislative Research, Dalhousie University

I should first of all point out that I am writing as a member of the legal profession and not as a representative of the Attorney General; I say this for a number of reasons, one being that the law relating to abortion in Canada at the present time is found principally in the Criminal Code, which, of course, is a federal statute, i.e. a statute of the Parliament of Canada.

The two Sections of the Code, *Sections 209* and *237*, strangely enough are not placed in relation to one another. *Section 237* is the original Section of the Code dealing with the offence of abortion as such. It has been in the Code since 1892 and is word for word the same as the original English Section of 1805. It is fairly straightforward, though originally the words "unlawfully uses any means" were employed in the Section - this is very important - but otherwise there is no exception under the Section for any medical purposes whatsoever. In *Section 209* of the **Criminal Code,** however, which deals with the causation of the death of a child who has not become a human being, there is the exception that it does not apply to a person who, in good faith, causes the death of the child if he considers this necessary to preserve the life of the mother or the child if it has not become a human being.

In *R. v. Bourne*, Judge McNutt, in his address to the jury, set out what he considered to be the English Law and working on the basis of the word "unlawfully" he imported into the abortion section the exception which was contained in the child killing section. He noted the absence of any specific exceptions in favour of therapeutic abortion in the Section under consideration. He held, however, that such an exception was implied by the word "unlawfully" contained in the Section. Referring to the phrase "for the preservation of the life of the mother" the Judge stated: "I do not think that it is contended that those words mean merely for the preservation of the mother from instant death. The law is not that the doctor has got to wait until the unfortunate woman is in peril of immediate death and at the last moment snatch her from the jaws of death. He is not only entitled, but it is his duty, to perform the operation with a view to saving her life." - this despite the fact that in *R. v. Bourne* there was no evidence in the case that there was any imminent danger to the life of the girl, but that the operation was for the sake of her general physical and mental health.

It is the English situation, therefore, that a therapeutic abortion is permissable even under the Section which it appears *prima facie* to prohibit. What is the situation in Canada? Dr. Lederman[1] holds there is a difference; he feels that the law is not the same in Canada. Certainly there is a great deal of uncertainty about this because we have no decision in Canada similar to the Bourne case, and the argument has to be made that the Bourne case is part of the law of Canada, as it has been the law of England since 1938. Although it is only a decision of a single judge, it has not been challenged by any superior court, so that the argument certainly pertains that it is part of the law, certainly of England.

It is my own view and the view of a number of legal writers in Canada that the Bourne case would be accepted as law in Canada; certainly a good many practitioners both in the medical profession and in the legal profession consider it to be part of our law, and I think it would be accepted as such. One of the reasons I say this is that similar provisions in the U.S. have been interpreted the same way, and I think that these would be of some influence on our Canadian judiciary. In the U.S. legislation in most instances there is no exception needed.

I should like to conclude by quoting from John White, Q.C., of Hamilton who made a submission to the Canadian Bar Association on this subject. In dealing with the Canadian law he stated in referring to the Bourne case: "It is, therefore, submitted that any doctor performing an abortion in a hospital setting in Canada would run no risk of prosecution if the mother's life would be in danger, or if the mother were to be exposed to grave physical or mental stress, if it were not performed. Certainly at present the economic circumstances of the mother or mere exposure of the mother to added emotional stress, or the possibility of a child being born deformed would not justify an abortion".

Reference

1. **Lederman, J. J.** *The Doctor, Abortion and the Law Canad.* M.A.J. **87**: 216-222, 1962

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P. N. B. Flemming, B.Sc., LL.M., Dip. Int. Law

Lecturer in International Institutions, Faculty of Law, Dalhousie University

The recommendations of the Canadian Bar Association and the Canadian Medical Association with respect to legalizing abortions are too conservative. I believe that the establishment of a "Termination Board" as recommended by the Canadian Bar Association Resolution of 1966 will lead to an overly-bureaucratic approach to what should be a swift and simple decision-making process. I am not willing to go so far as to say that a single doctor, with or without the advice of another qualified medical practitioner, should be entitled to have the final say with respect to whether a woman is to undergo abortion procedures.

The establishment of a Therapeutic Abortion Committee in every major hospital to decide the matter upon application from a woman's doctor would, in my opinion, provide the necessary safeguards for all parties concerned. A "Termination Board" could be used to the extent that any woman whose application is turned down by the individual hospital's Therapeutic Abortion Committee would be able to appeal at once to the Board for a final decision. Because the "Termination Board" would only hear such appeals then the numbers of persons applying to it would be cut down substantially from the present proposal of the Canadian Bar Association and thereby allow it to work quickly in a situation where time is of the essence.

The appeal to the "Termination Board" would have another advantage, namely, it could offset the decisions of an overly-conservative therapeutic abortion committee in any given hospital. Of course, the composition of the "Termination Board" will be important and I think it should be kept to as small a number of people as is feasible.

The grounds upon which a woman could obtain an abortion should be set out in any Statute governing the situation. The grounds should, however, be set out in as wide a form as possible to allow utmost discretion to the therapeutic abortion committee and the "Termination Board". Because the physical dangers connected with childbearing and allowing pregnancy to go to term are diminishing annually, there is no doubt that psychological reasons will account for nearly all abortions as approved by the committees and Boards. The reason for setting out grounds of a fairly specific nature is that it would provide a guidepost which could be used by the committees and Boards to prevent a wholesale abuse of the new situation.

Finally, by way of general comment on this sort of situation, I think that it is time that the Parliament of Canada established a permanent Law Reform Commission or appointed a permanent Law Reform Commissioner to review continually the whole problem of our statutes where they have obviously become antiquated and, worse, have not been complied with. A law which fails to conform to the general wishes of the community tends to bring the entire system of law into disrepute.

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D. F. Smith, M.D., C.M., L.C.S., F.A.C.P.O.G.

Chairman of Committee on Maternal Welfare, Medical Society of Nova Scotia, and Lecturer in Obstetrics and Gynecology, Dalhousie University.

I agree with the changes in the Criminal Code proposed by the Committee on Maternal Welfare and passed by the Council of the Canadian Medical Association in 1967. Currently approximately 500 therapeutic abortions are done yearly in Canada after hospital therapeutic abortion committees approve them. There have not been any criminal prosecutions of Canadian Medical doctors who perform therapeutic abortions in such circumstances, but it was felt by the Committee on Maternal Welfare that

members of the profession who perform these therapeutic abortions after approval by a hospital Therapeutic Abortion Committee should not have to fear prosecution.

The discussion of the proposed changes in the Criminal Code to permit therapeutic abortion advocated by the Canadian Medical Association and the Canadian Bar Association have been blown up by the lay press because of its news appeal. In Nova Scotia there were 37,286 live births and only 17 therapeutic abortions done during the calendar years of 1963 and 1964. It is necessary to avoid ethical and religious arguments when discussing therapeutic abortion because these are made on a personal and perhaps biased reasoning depending on the individual's past experiences, observations and beliefs.

It is important to realize that in some countries where abortion has been legalized the number of criminal abortions has increased rather than decreased. For example, this has been the experience in Japan where abortion is available through legal channels practically "on demand". In Japan when the number of legalized abortions reached 1,000,000 the number of criminal abortions surpassed this figure. This is probably explained by the fact that a large percentage of women who seek abortion wish to remain anonymous and therefore avoid legal channels and seek the criminal abortionist. In Sweden since therapeutic abortion became available through legal channels for certain medical indications after review by an abortion committee the number of therapeutic abortions decreased rather than increased.

The changes in the Criminal Code proposed by the C.M.A. and C.B.A. reflect a change in the attitude of Roman Catholics and others; an example of which is a statement in 1965 by Richard Cardinal Cushing of Boston in support of a proposal to legalize birth control information and devices in Massachusetts; "Catholics do not need the support of civil law to be faithful to their own religious convictions and they do not seek to impose by law their moral views on other members of society. It does not seem reasonable to forbid in civil law a practice that can be considered a matter of private morality."

At the time of writing this, it has been announced by the Minister of Justice that he proposes to introduce to parliament a change in the Criminal Code to legalize therapeutic abortion, but apparently he will not include in this proposal changes to legalize therapeutic abortion in the other two categories which have been proposed by the Canadian Medical Association and the Canadian Bar Association; namely the matter of a sexual offense resulting in pregnancy or where there is a substantial risk that the child may be born with a grave mental or physical disability. If this is correct it will continue to be illegal to perform therapeutic abortion for conditions where there is a high probability that an infant may be born with a severe congenital abnormality, such as in cases of maternal *rubella*. Research has demonstrated that women who have *rubella* in the first four weeks of pregnancy will give birth to infants with severe congenital anomalies in 61% of the pregnancies if the foetus does not die prior to term.

It should be stressed that the Committee on Maternal Welfare of the Canadian Medical Association realizes that even if the three recommendations for permitting legal therapeutic abortions are passed by parliament there will not be a decrease in the number of criminal abortions. Only a small number of abortions are done for the above three reasons. The two most common reasons for criminal abortion are that women have had too many children or that there has been conception out of wedlock. In various maternal mortality studies, abortion contributes up to 20% of the maternal mortality. This is not the experience in Nova Scotia as there have been 73 maternal mortalities and only one abortion death since June, 1958. In this one maternal mortality associated with abortion there was no suggestion of criminal interference as the patient herself was not aware that she was pregnant.

In answer to the second question I would hope that the Minister of Justice when proposing changes in the Criminal Code to legalize therapeutic abortion would also make changes in the Criminal Code legalizing contraceptive techniques and sterilization. I do not agree with those who favour abortions on demand, but would recommend that the "Therapeutic Abortion Committee" of the hospital should be the body which decides whether a therapeutic abortion is justified when continuation of the pregnancy will endanger the life or health of the pregnant female or where there is a substantial risk that the child may be born with a grave mental or physical disability. I agree with the recommendations of the Canadian Bar Association that a Provincial "Termination of Pregnancy Act" should be passed by each provincial legislature setting up a provincial "Termination Board" to receive applications, review and give approval for therapeutic abortion in the group of patients "where there are reasonable and probably grounds to believe that a sexual offense has been committed from which pregnancy has resulted"; such a board would be better equipped to take evidence, etc. in a proper legal manner and give or withhold permission for an abortion after a proper judicial review of the alleged criminal act which resulted in the pregnancy. The Canadian Bar Association also recommended that this "Termination Board" be the body that reviews and gives permission for therapeutic abortion where there is a substantial risk that the child may be born with a grave mental or physical disability, but in my opinion this latter group would be better left to the "Therapeutic Abortion Committee" of the hospital.

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J. McD. Corston, M.B., Ch.B., F.R.C.O.G., F.I.C.S., F.A.C.O.G.

Associate Professor of Obstetrics and Gynecology, Dalhousie University

Therapeutic abortion is illegal as the law stands at present. However, prosecution has not occurred if the abortion has been done openly in an accredited hospital after full consultation.

The C. M. A. resolutions suggest that Medicine wants the Law to make something *legal* which, in actual fact, has been practised for many years by the medical profession. This does not mean, however, in my opinion, that by this rather too little and too late approach by "The Johnny Come Latelies" that the back room abortions with consequent death and misery and chronic ill health will be lessened.

I believe that *women* should be more vocal and have the major voice in this serious question. Intelligent leaders who are women, who are mothers and who can speak for their sex should be heard and be invited to sit on public panels and on government committees, etc. to make known the *female point of view*. In this way the presumptuous male would in fact be placed in a secondary position, as he should be in this instance.

A Canadian medical centre carried out a pilot study at the "grass roots" amongst pregnant women at a pre-natal clinic. The patients belonged to a very low socio-economic class and the average education was between grade 8 and 9. One hundred and one patients were asked the question:

> *"If you had had the free choice of having an abortion in the first three months of this pregnancy, free of charge and without any danger of legal action against you, would you have had it done?"*
> *—Answer Yes or No with reasons.*

Results:

(a) 28 answered Yes they would have had the abortion, 71 answered No, two were undecided.
(b) Of the 28 who answered Yes: 21 were unmarried, five were married, two were separated.
(c) Of the 71 who answered No: 28 were unmarried, 42 were married, one was separated.

Therefore, less than one third of the total said "Yes, they would avail themselves of the opportunity" and three quarters of this group were unmarried or separated.

From these results it *may* be suggested that even if the abortion law was made more liberal than presently proposed, there might not necessarily be a mad rush by women to be aborted. Perhaps we are magnifying this danger.

In summary, then, I would propose that we should take this matter of abortion out of medical hands and set up machinery for dealing with these cases thus:

Any woman who wishes an abortion procured for physical, mental or sociological reasons applies to a Tribunal, consisting of:

1. Family Doctor
2. Social Worker
3. "Abortion Magistrate"

—the last-named preferably a women's leader who has had children herself. This Tribunal to call into consultation Medical Specialists, Gynecologists or Psychiatrists, as indicated. In this way any woman, *of her own volition*, would have free access to the Tribunal and with a minimum of delay.

This whole matter of Abortion is a very personal one and lawyers and doctors per se should not, in my opinion, place themselves in the position of great and wise judges as they have in the past, and will continue to do so in the future if the proposed *ultra conservative* changes in the law are passed.

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Keith B. Jobson, B.A., LL.M.

Assistant Professor of Law, Dalhousie University

Under the Criminal Code of Canada a doctor who performs an abortion stands a risk of being convicted and sentenced to imprisonment for life. A pregnant woman who procures an abortion for herself may be sentenced to two years imprisonment. It is a barbaric law fit for a barbaric people, but totally unfit for Canadians in 1967.

Abortions under the Code are prohibited by Section 237. No word of exception or justification mitigates its harsh decree. Many lawyers would argue that Section 237 must be read in the light of the saving clause found in Section 209 which prohibits the killing of an unborn child. Under that section a killing is justified if done to save the life of the mother. The Code does not make it clear, but Section 209 probably applies only to a viable foetus. Can the justification clause in Section 209 be used to justify the abortion of a non-viable foetus under section 237? No one will know until some judge decides an actual case. Personally, I think it is too much to ask a judge to read the two sections together and to write in a justification that Parliament expressly refused when it revised the Section in 1955. True, a judge in 1938 in the *Bourne* Case in England did do practically that, but our Canadian provisions while derived from the English law are more rigid and inflexible than the English law was at that time. In particular, our Section 237 omits the word "unlawfully". That word did appear in the English section, and using that word "unlawfully" as a hinge, the English judge was able to read into the Section a justification for abortions done to preserve the life or health of the mother.

Mercifully, then, only the good sense of the police in turning a blind eye to the common practice across the country saves many a doctor from ruin and disgrace.

The Canadian Bar Association in 1966 adopted a resolution justifying abortions done to preserve the life or health, including mental health, of the pregnant woman, or in cases where there is a substantial risk that the child would be born with a grave disability, or where the pregnancy has resulted from rape or other sexual attack. This is an extremely conservative position, further complicated by some administrative detail set out in the resolution. The approach taken by the Canadian Bar Association would do little more than bring the law into line with current practice. It would probably do little to cut down on the so-called "criminal" abortions, for most of these are sought for socio-economic reasons, a ground omitted from the Canadian Bar resolution.

What business has the criminal law in saying what operations a patient may have or a doctor may perform? With incredible officiousness the criminal law has universally imposed a particular code of moral values upon the public in a question of private morality. If a woman, married, perhaps with four children, wants an abortion, that's her business. If she sins that's a matter of private conscience, not a matter for the sledge-hammer force of the criminal law. To say that a woman must be prohibited from having an abortion, in the public interest, has only created a grave social problem, exposing women to serious mental anguish, driving them to seek illegal abortions in back-alley circumstances with resulting sterility, chronic illness, and death.

This year in England, Parliament, recognizing modern conditions, made abortion justifiable if the continued pregnancy would involve (1) risk to the life of the pregnant woman; (2) risk of injury to the physical or mental health of the pregnant woman; (3) risk to the well-being of her existing children; (4) substantial risk that the child if born would suffer such abnormalities as to be seriously handicapped. In weighing the risks to the future well-being of existing children as against the risks of continuing the pregnancy, a doctor may take into consideration the pregnant woman's actual or reasonably forseeable environment. Thus one of the greatest reasons for abortions—economic and social considerations—has been recognized by law.

Logically, there is no reason to categorize grounds of justification for abortion; logically the law should not prohibit abortions at all until the foetus becomes viable. After that point, the medical risks attending an abortion as well as the heightened sensitivity of the bulk of the population with respect to a viable foetus, suggest that abortion should be prohibited unless necessary to preserve the life or health of the mother. If the husband objects to the abortion that should be a matter for the civil law relating to families, not a matter for penal oppression. In short, let's stop making criminals of ordinary men and women.

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The comments we have received to our questions fall into three groups: Mr. Jones does not consider the law need be changed; Mr. Flemming and Dr. Smith doubt that the present recommendations will reduce the number of criminal abortions and would wish to widen the "therapeutic" indications; whereas Professor Jobson, Dr. Atlee and Dr. Corston would wish this matter removed from the Criminal Code altogether. I believe there is a fourth group who, recognizing that a child may not become a person under law until he has been born, nevertheless consider that he became an embryonic, emerging human being nine months previously. American law recognizes this and grants him the right to sue for damages while *en ventre de sa mère*. Many would argue that by no stretch of the imagination can the developing infant be considered a complete human being, but neither is the newborn baby, the paraplegic, the mental defective, the amputee or the geriatric patient.

My own concept of the matter, based on the humanity of the embryonic infant, is that abortion is a unique type of homicide and that just as homicide may be legalized in war or for judicial purposes, so may it also ethically be legalized for medical purposes if the child is menacing the life of his mother. In law self defence, up to and including killing of the aggressor, is accepted as legally justified, not only if the aggressor is morally at fault but also if he is, say, a lunatic. To be more rigorously opposed to the destruction of the child than to that of an adult man is surely unreasonable. In any view, however, it would be showing moral laxity to extend the grounds for legal infanticide to include eugenic or social reasons. I agree that a woman has rights over her own body, but the law does not extend these to the right that she take her own life. In my view neither has she the right to kill her children—certainly not for reasons of convenience. I am also opposed. to the argument that she, or her doctor, holds the power to decide that a child should be killed for his own good. I find the suggestion repugnant that infants in utero be killed because there is a 50 : 50 chance that there may be some congenital anomaly. Better far to follow a policy of selective infanticide after birth if Medicine is going to enter the field of eugenics. In these matters, therefore, I would support the bill presently before Parliament which limits therapeutic abortion to emergencies of life or health.

All would agree, however, that therapeutic considerations, no matter how widely they were interpreted, would represent only a miniscule proportion of the total number of abortions which are being performed, that is, mainly for reasons of convenience. Atlee, Corston and Jobson recognizing this, call for abortion on demand, with varying degrees of control. To most people this alternative appears to be inacacceptable. Just why this is so is not clear to me unless, like me, they hold that the developing foetus is

a human being—and this does not appear to be the general view. Nevertheless, the fact remains that most people, doctors, lawyers, legislators, and members of the public would not be in favour of abortion on demand, as it is practiced in Scandinavian countries and Japan. There are various possible alternative measures which certainly should be considered:

(1) **A concerted effort directed towards the prevention of unwanted pregnancies by-**

(a) wider dissemination of sex education, not only in the schools and homes, but also in the field of adult education.

(b) the wide provision of contraceptive knowledge and availability of medication or devices to the population at risk of pregnancy.

(c) revitalization of the churches, synagogues and moral agencies.

(d) the acceptance of the fact that there may be valid social indications for sterilization.

(2) **A realistic attempt to alleviate the problems presently associated with unwanted pregnancies-**

(a) revision of the present oppressive social strictures regarding illegitimacy.

(b) the provision of extensive provincial orphan facilities along the lines of child villages where unwanted children could be brought up in a home-like, family atmosphere.

(c) relaxation and revision of the presently ponderous regulations regarding adoption. □

Note- In our next issue we shall be publishing a statement by the Catholic Bishops of Canada on this subject, outlining the official view of the Roman Catholic Church.

I.M.

Book Reviews

Family Living and Sex Education - A guide for Parents and Youth Leaders - by S. R. Laycock.

"Sam Laycock through radio and television and writing and his professional life as an educator has for many years made very valuable contributions in the area of living adjustment, particularly on the Canadian scene. This latest volume continues in the same tradition."

Reviewers always show their prejudices and it is my opinion that Dr. Laycock's stressing of the attitudes and moral standards in all human interactions coincides with not only my own beliefs but reflects the experience of most trained youth counsellors. It has been established that the facts alone are far from enough, that our young people need encouragement and guidance and eventually they are more secure in making their free choice.

This guide should be of great value in this regard, not only for parents and youth leaders, but will also form valuable reading for almost everybody.

His list of recommended readings, particularly on Sex Education at the back of the book, as well as his very frequent references throughout the text can make this an excellent reference source.

Though on a few points the content is slightly repetitious, your reviewer has no major complaints or criticisms and can recommend this book most highly to physicians in their practice or even their own family life and it can be recommended with confidence for parents who seek help from their physician in answering the questions their children have that so often catch them unprepared." □

F.A.D.

"Handbook of Preventive Medicine and Public Health" by Murray Grant, M.D., D.P.H., Published in 1967 by Lea & Febiger, Philadelphia. Available in Canada from the Macmillan Company for $6.75. 242 pages, 20 tables and charts.

In his preface the author, who is Director of Public Health for the District of Columbia and also on the part-time teaching staff of both the George Washington University School of Medicine and the Howard University College of Medicine, writes: "This is not designed as an exhaustive text on the subjects of public health and preventive medicine. It is, however, my hope that this handbook will be found useful as an introduction, and that students will find it an interesting and informative approach to the basic fundamentals of public health and preventive medicine."

This small handbook does provide a comprehensive but brief picture of current public health problems, and it outlines the purposes and objectives of community services for the prevention and control of communicable and chronic diseases. Reference is made to such important topics as accidents and disaster planning, as wll as the value of genetics in public health. Finally, there are a few good charts and diagrams and there are short up-to-date references following each chapter, for those desiring additional information

Although suitable for use by all students in any of the health professions, the undergraduate medical student will have to supplement this book with selected reading from standard texts and specialty journals. □

A.C.I.

Maritime Medical Care Incorporated

The Annual Meeting of the Board of Directors, Maritime Medical Care Inc., took place on April 24, 1968. Immediately following this the first meeting of the new Board of Directors was held.

BOARD OF DIRECTORS M.M.C. Inc., 1968-69

Director	Branch Medical Society Represented	Appointment Expiring
Dr. J. McD. Corston	Halifax Medical Society	1969
Dr. H. B. Whitman	Pictou County Medical Society	1969
Dr. P. R. Little	Colchester-East Hants Medical Society	1969
Dr. A. M. Lawley	Inverness-Victoria Medical Society	1969
Dr. P. S. Mathur	Eastern Shore Medical Society	1969
Dr. W. H. Jeffrey	Shelburne Medical Society	1969
Dr. A. N. Lamplugh	Dartmouth Medical Society	1969
Dr. A. Gaum	Cape Breton Medical Society	1969
Dr. B. L. Reid	Halifax Medical Society	1970
Dr. R. A. Burden	Cumberland Medical Society	1970
Dr. G. W. Turner	Valley Medical Society	1970
Dr. T. B. Murphy	Antigonish-Guysborough Medical Society	1970
Dr. H. F. Sutherland	Cape Breton Medical Society	1970
Dr. M. E. DeLory	Lunenburg-Queens Medical Society	1970
Dr. R. P. Belliveau	Western Nova Scotia Medical Society	1970

Lay Members

Mr. J. A. Walker, Q.C.	Halifax	1969
Mr. J. N. Foster	Halifax	1969
Mr. David Zive	Halifax	1970

The Board of Directors Elected

Dr. J. McD. Corston - Halifax - President
Dr. T. B. Murphy - Antigonish - Vice-President

The Executive Elected are the President and Vice-President and -

Mr. J. N. Foster	Halifax
Dr. H. B. Whitman	Westville
Dr. R. A. Burden	Springhill
Dr. H. F. Sutherland	Sydney
Dr. G. W. Turner	Windsor
Mr. J. A. Walker, Q.C.	Halifax

Annual Report of the President

Gentlemen:

I am pleased to welcome you to our Corporation's 19th Annual Meeting. With the possible exception of the year in which M.M.C. was created, 1967 was perhaps the most significant in the Corporation's history. It was in 1967 that M.M.C. through negotiation with government significantly changed its future role in the field of physicians' services insurance.

On July 27th, 1967, the Minister of Public Health, the Hon. R. A. Donahoe, representing the Province of Nova Scotia, and your General Manager and I representing M.M.C., signed an agreement which provided for the use of our Corporation as the administrative vehicle for Medicare.

Briefly the arrangement provides that all policy matters respecting Medicare will be the exclusive domain of the Province's Medical Care Insurance Commission. Decisions relating to the amount and method of reimbursement to physicians, the range of benefits under Medicare, and method of raising the necessary funds to pay for the plan are matters which will be within the jurisdiction of the Province and the Commission. M.M.C. will merely provide

the personnel and facilities to carry out the Commission's policy decisions. The administrative arrangement for Medicare will be jointly designed by M.M.C. and the Province's Division of Administrative Services, subject of course to final approval by the Commission.

The Province has agreed that M.M.C. may continue to provide voluntary non-profit programs of health insurance for those health supplies and services which will not be benefits under Medicare. The Corporation will absorb the full cost of operating and underwriting such private plans.

The Corporation's Board structure will be changed to provide for five Directors to be appointed by the Governor in Council, replacing our present five non-medical Directors, and the Halifax and Cape Breton Branch Society representation on the Board will be reduced from two to one member each.

The agreement and revised By-Laws of M.M.C. formed part of the Medical Care Insurance Act which was passed by the recent sitting of the Legislature and received Royal Assent on Thursday April 11, 1968.

In view of the fact that the Medical Care Insurance Act defers the starting date of Medicare to April 1, 1969, the Minister has agreed to an amendment to our new By-Laws which will permit the present Board structure to remain in effect until December 31, 1968.

Before proceeding with a summary of our financial progress in 1967, two other matters affecting our operations should be reported. First, The Medical Society of Nova Scotia published a revised Schedule of Fees in August. This Schedule was reviewed and approved by the Board as the basis of payment of M.M.C. benefits for services rendered on or after October 1. Because the Corporation's medical plans had been losing money when payments were based on 1963 Fee levels, the Board made a second major decision namely, that a general rate increase take effect on November 1, 1967. Estimates made at the time suggested that the 33⅓ increase in premiums approved by the Board would probably not be sufficient to absorb the full cost of services on the new Fee Schedule. Preliminary information respecting our cost experience on the 1967 Fee Schedule is not yet sufficient to confirm or dispute our original estimates. Our Treasurer has predicted however that should enrolment remain constant and costs as incurred and paid during our first four months on the new Fee Schedule hold constant as well, we can expect a deficit on our Medical insurance plans approximating $631,000 by the end of 1968. This is a matter which will require your close attention in the year ahead.

1967 Financial Information

Returning to our 1967 Financial Reports, which we have just reviewed with the Auditor, it is interesting to note certain 1967 figures in the light of our 1966 experience.

Total subscription income for 1967 was $6,279,185 compared to $5,424,872, an increase of $854,313 or 15.7%. Total claims costs were $6,037,874 compared to $4,982,870 for 1966, an increase of $1,055,044 or 21.2%. Administrative expenses for 1967 totalled $694,158 compared to $581,491 for an increase of $112,667. When expressed as a percentage of revenue our 1967 administrative expenses were 11% compared to 10.7% in 1966.

Our operating deficit of $444,126 is entirely due to our losses on Physicians' Services plans as our Ancillary programs of Supplementary Hospital Care and Extended Health Benefits showed modest surpluses again this year.

The Medical Society of Nova Scotia has in recent years strongly recommended to this Board that it continue to improve the benefit range to subscribers so as to include all physicians' services and to accept the Schedule of Fees as published as the basis of payment for benefits. Experience is showing us however that although the Society appreciates our recent advances in these areas, M.M.C. is being discriminated against by many members of the Society who take lesser settlements from other underwriters and make no effort to recover the difference from or advise the patient of the difference. It has further been noted that some of the new benefits such as Directive and Continuing Care by Specialists are not being charged for when the patients insuring agency chooses not to declare such services as a benefit. There has been a sharp rise in the number of such cases since the new Fee Schedule was introduced and M.M.C. raised its premium rates in order to meet the added cost. The practice is so prevalent in certain areas of the province that several groups have been lost in recent months because other underwriters can now substantially undersell M.M.C. knowing that the patient's doctor will not charge for fee differences or uninsured services. Your concern with respect to this matter as expressed in a motion at last month's meeting, has been forwarded to the Medical Society and we are hopeful of some meaningful results.

With the delayed implementation date of Medicare the Corporation's present rate of drain on reserves is cause for concern. We have instructed our Actuarial Consultants to report on their adequacy and make recommendations as to a course of action.

Enrolment (see table page 161)

The above enrolment table reflects a reasonably steady rate of growth in our Group and Non-Group Comprehensive plans and a small decline in Health Security and Seniors' Health membership.

Our Supplementary Hospital plan membership has increased to 65,336 compared to 46,000 persons in 1966. The Extended Health Benefit plan has also increased steadily from 23,000 in 1966 to 36,000 in 1967.

Statement of Enrolment by Plan at December 31, 1967
Showing Gain or (Loss) over 1966

	No. Persons 1967	No. Persons 1966	Gain or (Loss)
Group Comprehensive	160,156	141,296	18,860
Non-Group Comprehensive	36,355	33,596	2,759
Health Security	2,999	3,253	(254)
Seniors' Health Plan	12,167	13,593	(1,426)
Totals	211,677	191,738	19,939

Our Sales Department reports that 146 new groups were enrolled in 1967 and that 90% of these groups purchased our Supplementary Hospital Benefit Plan in addition to Medical Care coverage.

Physician Relations

Our Participating Physicians are generally quite satisfied with recent M.M.C. progress in matters affecting them directly. The 1967 Schedule of Fees was accepted as the basis of payment within sixty days of its publication and the benefit range on the Comprehensive Plan was broadened earlier in the year.

Our Medical Director continued with his series of regional seminars for Medical Secretaries, Office Assistants and Hospital Administration staffs. These seminars have proved helpful to all and will be continued.

Although Medicare planning did prevent us from having an M.M.C. representative at all Branch Society meetings, your General Manager, Medical Director, Vice-President and I attended as many meetings as possible. In spite of the efforts of the Medical Society's Executive Secretary to space out these meetings over a four to six week period, postponements and re-scheduling usually resulted in three or four meetings being held in the same day, making it most difficult to have a member of our Senior Administrative staff present at all meetings.

Last year for the second time the Board of Directors held one of its regular meetings in conjunction with the Medical Society's Annual Summer Meeting at Digby. Ths proved very successful as it conveys to all the close relationship that exists between the Society and the Plan. Although we hope that this relationship may continue for many years to come there is a definite possibility that the medical profession's interest in continuing this relationship will wane when M.M.C. withdraws as the major underwriter of physicians' services and reverts to a purely administrative role.

T.C.M.P. Activities

Only one major meeting of Trans Canada Medical Plans was held in 1967. This was held in Montreal in co-operation with the Canadian Medical Association's Centennial celebration. Our representatives Dr. Byron Reid and Mr. Brannan attended the Commission meetings and thirteen Directors and senior administrative personnel participated in the joint C.M.A.-T.C.M.P. Economic and Manpower sessions. Our T.C.M.P. Commission representatives report that due to the air of uncertainty about the future of various doctor-sponsored plans under their respective provincial Medicare plans, very little was accomplished.

Conclusion

In conclusion I would repeat my opening statement that this was a very important year in M.M.C.'s history. I would like to thank all the Directors who worked on extra committees during the year and particularly Dr. Corston and Mr. Walker who served with our General Manager and Medical Director on the Committee which negotiated with the Province on our behalf.

I would also like to acknowledge the services of those Directors whose terms expire to day and are attending their last meeting, and to Mr. Victor Thorpe of Kentville who resigned on election to the Legislature.

I would also like to thank on our behalf the administrative staff of M.M.C. who have had a particularly busy year operating our regular programs and planning for Medicare. We are most appreciative of their loyalty and efforts on behalf of the Corporation.

Finally may I say how much I have enjoyed serving as President for the past three years and to express my personal appreciation to each of you for your co-operation and assistance.

Respectfully submitted,

H. B. Whitman, M.D.,
President.

Auditors' Report

We have examined the balance sheet of Maritime Medical Care Incorporated as of December 31, 1967 and the statement of income and expenses and general reserve for the year then ended and have obtained all the information and explanations we have required. Our examination included a general review of the accounting procedures and such tests of accounting records and other supportig evidence as we considered necessary in the circumstances, including verification of bank balances and investments.

In our opinion, and according to the best of our information and the explanations given to us and as shown by the books of the corporation, these financial statements, together with the notes thereto, are properly drawn up so as to exhibit a true and correct view of the state of the affairs of the corporation at December 31, 1967 and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Halifax, N. S.
April 10, 1968

PEAT, MARWICK, MITCHELL & CO.
Chartered Accountants

BALANCE SHEET
December 31, 1967 (with comparative figures for 1966)

ASSETS

		1967	1966
Cash on hand and on deposit		$ 255,953	$ 356,482
Accounts receivable		203,936	175,652
Prepaid expense		764	618
Accrued interest on investments		42,341	42,062
Investments, at cost:			
General funds		2,912,577	2,973,752
Restricted funds		41,761	41,761
Quoted market value			
December 31, 1967	$2,623,049		
December 31, 1966	$2,872,663		
Inventory of supplies, at cost		22,040	14,322
Furniture and office equipment, at cost		82,065	79,144
Less accumulated depreciation		51,757	45,412
Net furniture and office equipment		30,308	33,732
		$3,509,680	$3,638,381

LIABILITIES

	1967	1966
Cheques issued, but not presented for payment	$ 310,803	$ 369,602
Subscribers' claims payable	1,231,352	949,476
Unpresented subscribers' claims, estimated	440,303	331,851
Accounts payable	13,245	13,753
Trust funds - Province of Nova Scotia Welfare Plan	80,660	126,612
Subscriptions received in advance	133,836	127,976
Payable re railway contract, estimated (note 1)	18,625	158,063
Total liabilities	2,228,824	2,077,333
Restricted funds:		
Contingency reserve, re railway contracts	41,761	41,761
Retained by the Corporation:		
For stabilization of payments to physicians	90,769	359,276
Reserve for decline in market value of investments	200,000	100,000
Reserve for Employee Retention Plan	235,000	235,000
General reserve, per statement attached	713,326	825,011
Total retained	1,239,095	1,519,287
	$3,509,680	$3,638,381

STATEMENT OF INCOME AND EXPENSE AND GENERAL RESERVE

Year ended December 31, 1967

With comparative figures for 1966

	1967	1966
Subscription income	$6,279,185	$5,424,872
Expenditure:		
Medical care for subscribers		
Current year medical claims paid or provided for	6,037,874	4,982,870
Less:		
Provision for medical claims in prior years in excess of amounts paid	8,721	(84,236)
	6,029,153	5,067,106
Administration costs, Schedule 1	694,158	581,491
Total expense	6,723,311	5,648,597
Operating deficit	444,126	223,725
Other income:		
Income from investments	173,204	165,049
Sundry	2,415	1,677
	175,619	166,726
Net deficit for the year	268,507	56,999
Appropriation from:		
Reserve for stabilization of payments to physicians	268,507	56,999
	—	—
Appropriation to:		
Reserve for decline in market value of investments	100,000	70,000
Adjustment of amount payable re mutualization of 1965-66 railway contract	11,685	—
	111,685	70,000
Balance appropriated to General Reserve	(111,685)	(70,000)
Amount of General Reserve at beginning of the year	825,011	895,011
	$ 713,326	$ 825,011

Notes to Financial Statements

December 31, 1967

1. Effective January 1, 1967 the Corporation entered into a two year contract, in conjunction with similar medical service plans in Canada, to provide medical coverage for the employees of Canada's railways. The contract provides that at its termination the experience of the participating plans will be reviewed in order to determine the net gain or loss from the contract. The experience of each plan is then related to the experience of the group as a whole, and then appropriate financial adjustments are made among the plans. Based on the experience of the Corporation on this contract, it is estimated that at December 3 1967 a refund by the Corporation to the participating plans of approximately $18,625 will be required.

2. Under the terms of the agreement between the Corporation and the participating physicians, the Corporation may, after the expiration of a twelve month period, cancel any unpaid balances outstanding on approved claims. The Board of Directors has passed the necessary resolution to cancel all such unpaid amounts to December 31, 1966. □

Vaginal and Uterine Lacerations*

Reprinted from The Canadian Medical Association Journal, July 30 1966, Vol 95, p. 219

A 29-year-old primipara, married for nine years, made her first prenatal office visit to her attending physician when she was 12 weeks pregnant. She made prenatal office visits monthly up to 34 weeks' gestation and then every two weeks until term. She had always enjoyed good health. During the pregnancy her total weight gain was 35 lb. and she had been cautioned during her prenatal office visits about the excessive weight gain. The blood pressure and urine were normal throughout the pregnancy and the hemoglobin (Hb.) was 11 g. % at term. She received supplementary prenatal iron and vitamins from the twelfth week of pregnancy to term.

She was admitted to the first hospital at term in labour, and the cervix was 3 cm. dilated when she was examined by the attending physician four hours after her admission to the hospital. During the first 12 hours of her labour in hospital she was given 30 mg. of alphaprodine hydrochloride (Nisentil) on two occasions and 90 mg. of pentobarbital sodium (Numbutal).

The attending physician and his partner both examined the patient vaginally 19¾ hours after her hospital admission. The membranes were ruptured and "the cervix was almost completely dilated". They discussed the possibility of performing a Cesarean section because of the "slow progress."

The patient was allowed to continue in labour for another hour and then vaginal examination showed that the fetus was presenting in the posterior occiput position and had descended to the level of the ischial spines. Operative delivery was accomplished under incomplete ether anesthesia using Kielland forceps for the forceps rotation of the posterior occiput to the anterior occiput position and then Simpson forceps for the extraction. Considerable traction was necessary and the attending physician "felt something give and then the delivery was easy". The 7-lb. baby had marked moulding and bruises of the cranium. The infant died one and one-half hours after the delivery despite resuscitation using oxygen, mouth-to-mouth breathing, adrenaline (Adrenalin) and nikethamide (Coramine). An autopsy was not done on the fetus; however, the attending physician considered the neonatal death to be due to the traumatic delivery. Following the delivery of the placenta, 15 minutes after the delivery of the fetus, the patient received 0.2 mg. of methylergobasine maleate (Methylergobasine) and 0.25 mg. of ergotamine tartrate (Gynergen) intravenously. She was transferred to the postpartum area with a systolic blood pressure of 140 mm. Hg. three-quarters of an hour after the delivery. Shortly after her arrival on the ward it was noted that the vaginal bleeding was excessive; a large clot was expressed vaginally and she was given 0.2 mg. of methylergobasine maleate intravenously.

She became very restless one and one-quarter hours after the delivery and the systolic blood pressure was 90 mm. Hg. Emergency Group O Rh-negative blood, 500 c.c. of 5% glucose and water and dextran (Dextraven) were given intravenously. The patient complained of ascending right lower quadrant pain. Arrangements were made for the patient's transfer to a larger hospital. She was given 50 mg. of pethedine hydrochloride (Demerol) She left the first hospital by ambulance two and three-quarter hours after the delivery.

She was admitted to the second hospital in severe hypovolemic shock with a systolic blood pressure of 40 mm. Hg, and was given additional emergency Group O Rh-negative blood and dextran intravenously. She was taken to the operating room three-quarters of an hour after her admission to the second hospital. At this time she had a perceptible pulse and her blood pressure was 90/60 mm. Hgs The uterus was firm and the vaginal blood loss was excessive. Vaginal examination showed that there were deep sulcus lacerations on each side of the vagina extending up to the lateral fornices of the vagina and the "vagina appeared to be sheared off." The vaginal lacerations were sutured as well as possible. The uterine cavity was examined with two fingers, and the obstetrician did not feel any uterine perforation or retained placental fragments. A retention Foley catheter was inserted and blood drained from the bladder. The consultant felt that although additional uterine and bladder trauma could not be excluded at this time, the patient's condition was too serious for further investigation and the vagina was packed with gauze.

The patient received 4500 c.c. of blood and 10 c.c. of 10% calcium gluconate intravenously in the first four hours of her admission to the second hospital. She was returned to the operating room three and one-quarter hours after admission to the second hospital because of continuous bleeding through the vaginal packing. At this time the blood pressure was 110/70 mm. Hg but was dropping slowly.

*This series of articles arranged by an editorial subcommittee of the C.M.A. Committee on Maternal Welfare, and originally published in the Canadian Medical Association Journal, is being reproduced in the Bulletin at the request of The Medical Society of N. S. Committee on Maternal and Perinatal Health, by kind permission of the Editor of the Canadian Medical Association Journal.

additional vaginal suturing was done and the obstetrician considered performing intra-arterial transfusion or laparotomy with ligation of the internal iliac vessels, but he felt that the patient's condition was "too precarious for further surgery". The patient deteriorated rapidly despite additional blood transfusions and she died five hours after admission to the second hospital (nine and one-quarter hours after the delivery).

A complete autopsy demonstrated two perforations of the lower uterine segment measuring 1.2 cm. and 0.7 cm.; multiple sutured vaginal lacerations; 1000 c.c. of intra-abdominal hemorrhage and 2000 c.c. of retroperitoneal hemorrhage.

Decision of the Provincial Committee on Maternal Welfare

The conclusions reached by the Provincial Committee on Maternal Welfare after a review of this case were as follows: "This was a preventable direct maternal death. The cause of death was shock due to hemorrhage from vaginal and uterine lacerations which resulted from a difficult forceps rotation and extraction. The preventable professional factors were inadequate prenatal assessment of the pelvis, inadequate maternal sedation during labour, not permitting the patient to have a longer second stage of labour, attempting a difficult forceps rotation and extraction in a hospital where inadequate facilities were available for the serious complications which occasionally result from such obstetrical procedures, failure to examine completely the birth canal, inadequate consultation and inadequate blood replacement before the patient's transfer to the second hospital. In addition it was considered possible that a laparotomy with total hysterectomy and probable bilateral ligation of the internal iliac vessels once the patient had been partially resuscitated might have been life-saving. This maternal death has been considered to be ideally 'preventable' under the terms of reference of the Provincial Maternal Welfare Committee and there is no implication of any negligence."

Discussion

This primipara had a fairly normal course of labour, although cervical dilatation was slow. She received inadequate sedation during labour and instead of being given two doses of 30 mg. of alphaprodine hydrochloride she should have received more adequate sedation, such as 75 mg. of pethedine hydrochloride and 25 mg. of promethazine (Phenergan) or 50 mg. of promazine hydrochloride (Sparine) intramuscularly.

When the cervix was found to be incompletely dilated 19¾ hours after admission to the first hospital, the membranes should have been artificially ruptured, and the patient should have been returned to the labour bed and given additional sedation. When the fetus is in a posterior occiput position and a rim of cervix is remaining, it is not unusual for a primipara to take two or more hours to achieve full cervical dilatation. Furthermore, this patient should have been allowed an additional two hours of labour after full cervical dilatation had occurred, to give the normal forces of labour a chance to push the head to the pelvic floor and even possibly to allow spontaneous rotation of the posterior occiput to the anterior occiput position.

It is only after the progress of the fetus has been arrested for two hours after the cervix is fully dilated without evidence of fetal distress that a "trial forceps" should be considered. "Trial forceps" is an accepted obstetrical procedure but should only be carried out with adequate anesthesia, trained personnel and instruments immediately available for Cesarean section if the head cannot be delivered by forceps with *relative ease*. As demonstrated by this case, mid-forceps rotation may on occasion result in severe trauma to the birth canal which makes necessary the immediate availability of adequate anesthesia, obstetrical consultants and facilities for the treatment of shock due to massive blood loss. If a hospital lacks such personnel and facilities, the patient should be transferred to the nearest hospital possessing these facilities before such procedures are attempted. Most rural communities are now served with good highways permitting rapid evacuation. Air transport is now commonly used for more distant or isolated areas. In at least one province an "Emergency Obstetrical Team" is available which in such emergencies will go (by air, if necessary) to any point in the province. Also the C.M.A. Committee on Maternal Welfare has recommended that physicians practising obstetrics in areas with incomplete facilities and/or personnel establish liaison with specialists in neighbouring centres so that there will be immediate telephone consultations and/or early and rapid patient transfer to a better equipped hospital when such obstetrical emergencies occur.

After a difficult mid-forceps procedure or when postpartum hemorrhage occurs, a complete examination of the birth canal (the vagina, the cervix and manual exploration of the uterine cavity) should be done to exclude rupture of the uterus. To do an adequate manual exploration of the uterine cavity, it is recommended that the right side and the anterior aspect of the uterus be examined using the right hand, and the left side and the posterior aspect of the uterus be examined using the left hand. In this case, the attending physician did not examine the entire birth canal and the consultant could not perform this examination adequately because, owing to hemorrhagic shock, anesthesia could not be given to relax the uterus.

It must be remembered that when catastrophic obstetrical hemorrhage occurs, the attending physician cannot afford to procrastinate but must immediately put into action a prearranged plan of rapid massive blood procurement and administration, ex-

amine the entire birth canal for the cause of the hemorrhage, to treat the cause; and obtain immediate adequate consultation.

A ruptured uterus calls for an immediate laparotomy and resuscitative measures including the administration of massive blood transfusions. Retroperitoneal hemorrhage from traumatic rupture of the uterus often markedly distorts the pelvic anatomy. Even total hysterectomy often does not control the bleeding, and bilateral ligation of the internal iliac vessels may be necessary. During laparotomy, manual compression of the aorta at the pelvic brim is helpful in controlling the hemorrhage. It should be stressed that the surgery necessary in such instances may be very difficult technically, and the best available surgical assistance should be obtained. When a ruptured uterus occurs, the attending physician should request immediate assistance from as many of his colleagues as necessary.

With such vaginal and uterine lacerations as were encountered in this case, it is impossible to maintain or improve the patient's condition by blood replacement alone. The patient will die unless immediate massive blood replacement is accompanied by immediate laparotomy with total hysterectomy and possibly by bilateral ligation of the internal iliac vessels. These procedures should be done by a surgeon who is familiar with pelvic anatomy and with the marked distortion of this anatomy that occurs with the retroperitoneal hemorrhage that follows vaginal and uterine laceration.

Summary

A maternal death was reviewed by the Provincial Committee on Maternal Welfare. The cause of death was massive intra-abdominal, retroperitoneal and vaginal hemorrhage due to birth canal lacerations following forceps delivery. The preventable factors are discussed.

□

Public Health News

Glue-Sniffing

A campaign to educate the young people of Nova Scotia on the dangers of glue-sniffing has been launched by the Department of Public Health.

The Department, in cooperation with the Department of Education and the new Youth Agency last May sent copies of their pamphlet "Glue-sniffing" accompanied by a covering letter to school principals throughout the province.

The letter pointed out that over the past few months the Department had been made aware that a number of young people in the province are participating in the dangerous habit of glue-sniffing. "The habit causes the glue-sniffer to have a psychological dependence on glue which may later on make the glue-sniffer turn to stronger drugs. The habit can also cause a number of serious disorders within the body itself.

An informal survey taken of school principals in one area of the province shows there are a number of glue-sniffers known to the principals and it is felt there are more cases which have yet to be discovered by teachers and principals.

The Department of Public Health feels, that most young people, whether they go in for the habit or not, know how to get high on a number of other substances such as toluene, nail polish remover, and gasoline."

Signed by Dr. J. S. Robertson, deputy minister of public health, H. A. Weir for the deputy minister of education, and Greg Donovan, commissioner of youth, the letter asks the principals to "see the pamphlet gets into the hands of those teachers most direcly concerned with students who may be facing the problem of glue-sniffing."

The letter was sent to principals of schools covering grades four to twelve located outside the city of Halifax. School teachers in the city had received the pamphlet earlier in the year from the city health department.

The purpose of the campaign is to have the teachers present the facts of glue-sniffing and let the young people decide for themselves the wisdom of continuing to glue-sniff.

Dr. H. B. Colford, director of maternal and child health, said "the big danger with glue-sniffing was that excessive inhalation of its vapours could easily lead to unconsciousness or partial blackouts during which the sniffer might suffocate with the plastic bag over his face." He said many deaths had been caused in this way.

"Prolonged glue-sniffing," he said, may "also cause damage to the vital organs of the body such as the liver, kidneys, and even the brain. A fatal anemia may also be caused by glue-sniffing."

He said glue-sniffing causes the individual to lose control of himself to the extent that he often did not know what he was doing when under its influence.

Glue-sniffers often have a tendency, he said, to "develop a craving for effects of the vapour so much so that they find it very difficult to give up the habit."

Tuberculosis

The number of Nova Scotians dying from tuberculosis increased in 1967, Dr. J. E. Hiltz, administrator, Tuberculosis Control Services, Department of Public Health, said in a report.

Thirty-three persons had been "certified as dying either directly because of, or indirectly due to tuberculosis" in 1967 compared with 20 in 1966, he said. Only three counties, Queens, Shelburne, and Richmond, did not record a tuberculosis death during the past three years.

"Less than half the deaths (15) from tuberculosis occurred in our tuberculosis hospitals. Almost as many (11) occurred in general hospitals and six of them occurred in their own homes where they must have been a hazard to home contacts," Dr. Hiltz said.

If tuberculous patients must die, he said, "it would be preferable for them to die in a sanatorium or tuberculosis hospital where staff are accustomed to taking the requisite sanitary precautions to diminish the hazard of spread of tuberculosis infection to others."

Advanced Tuberculosis Cases

A great many patients are still being admitted to tuberculosis hospitals with their disease in an advanced stage stated Dr. J. E. Hiltz, medical superintendent of the Nova Scotia Sanatorium.

He cited the example of a 74-year old man who had been admitted to the Sanatorium with far advanced pulmonary tuberculosis and sputum loaded with tubercle bacilli. He died the day after admission.

Dr. Hiltz pointed out this man had been a patient at the Sanatorium in 1929 with moderately advanced tuberculosis. The man had said he had not had a chest X-ray since 1929. However, the man was not even known to the health unit director as a case of tuberculosis.

Dr. Hiltz stressed the following points:

1. Age is no barrier to active tuberculosis.
2. The fact that the patient, apparently did not reactivate until 38 years after his original treatment period stresses the need for yearly assessment of all old healed cases.
3. Far advanced infectious tuberculosis very frequently occurs in "old people".
4. A Provincial Case Register might have helped in following up this case over the past 35 years by "bringing forward" this case to the attention of the Health Unit Director.

Smoking Studies

Studies at the Nova Scotia Sanatorium have confirmed the "remarkable relation between heavy cigarette smoking and cancer noted by many other investigators", Dr. John Quinlan, a member of the surgical staff, said.

The confirmation came from studies involving 150 patients over a period of nine years with respect to their smoking habits, he said.

Dr. Quinlan called for improvement in the survival rate from cancer by directing efforts towards prevention. Efforts should be particularly aimed at young people by "trying to convince them that there is an undoubted relationship" between cigarette smoking and the development of lung cancer.

"They will be making a most important decision for themselves if they decide not to take up smoking."

Dr. Quinlan pointed out that 4,000 persons died in Canada in 1966 as a result of cancer of the lung. Every adult, particularly males over 40 years of age, should have a chest X-ray examination at least once a year.

"Cancer cells can be found in secretions from the lungs in very early stages in many cases, particularly types caused by cigarette smoking", he said.

The Rehabilitation Division of the Nova Scotia Department of Public Health will be officially transferred to the Department of Public Welfare, April 1, 1968. The move comes about as a result of a recommendation of the Welfare Ministers Advisory Committee on Rehabilitation.

Frank Wellard, coordinator of Rehabilitation Services, said this was being done "for practical reasons and to provide better services to more handicapped persons."

WHO Appointment

Dr. C. E. vanRooyen, head of the Division of Bacteriology, Nova Scotia Department of Public Health, has been appointed to the World Health Organization expert advisory panel on virus diseases for a period of five years.

Births, Marriages, Deaths 1967

Nova Scotians seem to be marrying more, having fewer babies, and dying in greater numbers in 1967 than they were in 1966.

A total of 14,737 babies were born in Nova Scotia in Canada's Centennial year compared with 15,136 for 1966 and compared with 16,648, the average for the years 1964-1966.

In 1967 there were 6,217 marriages, slightly more than the 1966 total of 5,815 and representing a greater increase over the three year average of 5,563.

There were 6,672 deaths recorded for the Province for 1967 an increase over the 6,452 recorded for 1966 and over the 6,401 recorded for the three-year average.

Diabetic Drugs

Administration of the program that provides free insulin for the control of diabetes has been transferred from the provincial health department to the Department of Public Welfare.

Purpose of the transfer of the program's administration to enable the province to take advantage of the cost sharing provisions of the Canada Assistance Plan. As a result of the change, new methods will be introduced to determine an indvidual's eligibility for the program and a very considerable amount of new money will be provided through the Canada Assistance Plan.

Eligibility for free insulin drugs and testing materials up to now has been based on a $3600 family ceiling per annum. With the transfer to the welfare department the eligibility requirements will be based on a family budget which takes into consideration requirements for food, clothing, rent, home ownership, personal needs and special dietetic foods. The total family budget will then be compared with the total income of the diabetic and his spouse and free medication will be granted in those cases where budget requirement is greater than the income. □

Transactions

3rd Meeting of Council and 114th Annual Meeting

Medical Society of Nova Scotia

Hotel Nova Scotian – November 24th and 25th, 1967

Third Meeting of Council - Index

114th Annual Meeting - Index

Third Meeting of Council (1967)

INTRODUCTORY NOTES

The 3rd Meeting of the Council of the Society and the 114th Annual Meeting was held in the Hotel Nova Scotian, Halifax.

Guests invited to attend Meetings of Council were:—Dr. N. J. Belliveau, Canadian Medical Association; Mr. B. E. Freamo, Executive Secretary, Canadian Medical Association; Mr. D. A. Geekie, Secretary, Public Relations, Canadian Medical Association; Honorable R. A. Donahoe, Minister of Public Health; Mr. R. McD. Black, Chairman, Medical Care Insurance Advisory Commission; Mr. S. S. Jacobson, Medical Care Insurance Advisory Commission; Mr. J. H. Delaney, Medical Care Insurance Advisory Commission; Mr. W. J. MacInnes, Q.C., Legal Counsel for Medical Society of Nova Scotia; Mr. S. P. Brannan, General Manager, Maritime Medical Care Inc., Mr. D. Waller, Executive Secretary, Medical Care Insurance Advisory Commission; Dr. F. L. Whitehead, Secretary, New Brunswick Medical Society; Dr. R. A. Hopper, President, New Brunswick Medical Society; Dr. W. David Parsons, Honorary Secretary, Newfoundland Medical Society; President of Newfoundland Medical Society; President of Prince Edward Island Medical Society. Representatives of Affiliated Societies—Mr. R. E. J. Ricketts, Executive Secretary, Nova Scotia Tuberculosis Association; Mr. J. A. MacGlashen, Executive Secretary, Nova Scotia Rehabilitation Council; Mr. R. B. Hayward, Executive Secretary, Nova Scotia Division, Canadian Arthritis & Rheumatism Society. Other guests: Mr. Meng Tan, President, Dalhousie Medical Students Society; Mr. Wayne Putnam, Senior Representative, Canadian Association Medical Students & Interns; Mr. Stephen Brown, President, 5th Year Class, Dalhousie Medical Students, Mr. W. H. Lenco, Vice-President, 5th Year Class, Dalhousie Medical Students; Mr. Murdock Smith, President, 4th Year Class, Dal. Medical Students; Mr. William Parsons, President, 3rd Year Class, Dal. Medical Students, Mr. Joel Kirsch, President, 2nd Year Class, Dal. Medical Students; Mr. Heinz Scholz, President, 1st Year Class, Dal. Medical Students.

The Council of the Society held three Sessions)—

Friday, November 24th 9:30 a.m. – 1:00 p.m.
Friday, November 24th 2:30 p.m. – 6:00 p.m.
Saturday, November 25th 9:30 a.m. – 1:00 p.m.

There were two Sessions of the 114th Annual Meeting:—

Friday, November 24th 6:00 p.m. when the Nominating Committee reported and the Officers for 1967-68 were elected.
Saturday, November 25th 1:00 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 (1966-67) on Thursday, November 23rd. The Committee on Committees met on Friday, November 24th at 8:00 a.m. and Saturday, November 25th at 8:00 a.m.

The 1st Meeting of the incoming Executive Committee was held on Saturday afternoon, November 25th 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 Scientific Programme for the Annual Meeting was the 41st Annual Dalhousie Refresher Course, November 20th to November 23rd inclusive. Joint registration was available, in the Arcade of the Sir Charles Tupper Medical Building, for the Meeting of Council, the Annual Meeting, and the Scientific Programme thus covering the period, November 20th to November 25th inclusive. 75 registered for the Scientific Programme.

136 had been designated as representatives to Council. 60% of that number registered. Attendance at Sessions of Council ranged from 85 to 100.

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

A Programme for the ladies had been arranged by Mrs. G. McK. Saunders and Mrs. S. C. Robinson.

The President's Reception, Annual Banquet and Annual Ball took place on Friday evening, November 24th.

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

The President, Dr. G. McK. Saunders, Chaired the Sessions of Council, the Sessions of the Annual Meeting and presided at the Reception, Annual Banquet and Annual Ball.

Distribution of Reports

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 24th, 9.30 a.m.

AC1—The President, Dr. G. McK. Saunders, as Chairman of Council, called the meeting to order at 9.40 a.m. 82 members of Council were present. He extended a welcome to the guests, particularly Dr. N. J. Belliveau, President, C.M.A., Mr. B. E. Freamo, Executive Secretary, C.M.A., and Mr. D. A. Geekie, Secretary, Public Relations, C.M.A.

AC2—The Chairman read the names of the members deceased between October 31st 1966 and November 6th 1967 as follows: –

Barss, G. A., M.D., January 27, 1967
Calder, Allister, M.D., July 1967
Doull, A. E., M.D., April 19, 1967
Havey, H. B., M.D., May 4, 1967
Johnston, S. R., M.D., November 1, 1967
Kirk, T. E., M.D., January 4, 1967
MacLean, J. R., M.D., March 16, 1967
Patton, W. W., M.D., November 1966
Phinney, W. M., M.D., June 20, 1967
Murray, Daniel, M.D., July 16, 1967
Schwartz, H. W., M.D., November 1966
Williamson, S. W., M.D., October 20, 1967

The Chairman requested two minutes of silence in tribute to the memory of these deceased members.

AC3—The Chairman then read the names of 67 physicians who had applied for membership in the Society between October 30th 1966 and October 30 1967.

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

AC4—The Transactions of the Sessions of Council 1966 and the Annual Meeting 1966, as printed in the October 1967 issue of The Nova Scotia Medical Bulletin were, on motion adopted.

AC5—The Chairman named Drs. Devereux and Griffiths to be the Resolutions Committee for the meeting.

REPORTS OF COMMITTEES & REPRESENTATIVES

AC6—**The Executive Committee:**—(AR p. 1-4) Chairman, Dr. S. C. Robinson.

Dr. Robinson reported on 18 items of important business transacted by the Executive during the year including the action of the Committee of the Committee on Legislation & Ethics in reference to opposition to a Chiropractic Bill which did not go beyond a second reading, and was defeated; and recommendations that the Executive Secretary be authorized to initiate proposed dates for scheduled branch meetings; that a special $10.00 levy on members to provide financial support for the activities of the P.S.I. Committee be authorised, and that an expression of thanks be made to M.M.C. for a grant of $5,000. to defer the expenses of the P.S.I. Committee.

AC7—He reported that the Executive had welcomed the Dalhousie Medical Student Society as an affiliate Society; that the Provincial Medical Board is undertaking a review of the Medical Act of Nova Scotia; that Universal Membership in the M.S. of N. S. has been closely studied and referred to the Committee on Membership, whose recommendations will be reported to Council, and that limitations have been placed on the activities of the Executive Secretary for medical reasons.

AC8—On motion of Dr. Robinson, seconded by Dr. Weil, the Report was accepted for information. The President, Dr. Saunders, thanked Dr. Robinson for his good work as Chairman of the Executive Committee for the last three years.

AC9—**Physicians' Services Insurance Committee:** (AR p. 68-75 and Supp. Report p. 94-95), Chairman, Dr. G. McK. Saunders (President).

Dr. Saunders reviewed his report, stating that the P.S.I. Committee had held 16 meetings during the year and had met with the Medical Care Insurance Advisory Commission on 9 occasions. All meetings had been attended by Legal Counsel to the P.S.I. Committee, Mr. W. J. MacInnes, Q.C.

AC10—He referred to Memorandum # 20 to the Planning Commission which had included a resolution from the Executive Committee: –

RE3'67 # 16:

Moved by Dr. A. J. M. Griffiths
Seconded by Dr. G. McK. Saunders.

"THAT The Medical Society of Nova Scotia will not support legislation for the implementation of a government sponsored plan for pre-paid medical care unless the legislation recognizes that the Medical Profession and the Government jointly share the responsibility for the implementation of such a Plan as equals and that nothing in the legislation either directly or indirectly establishes a master-servant relationship between the Gov't. and the Medical Practitioner,

AND BE IT RESOLVED THAT:

this resolution be transmitted to the Medical Care Insurance Advisory Commission by the Physicians Services Insurance Committee at their next joint meeting." CARRIED.

AC11—The report included 9 items with which the P.S.I. Committee had been primarily concerned, namely: –

1. Consideration of actuarial findings in comparing provincial fee schedules.
2. The study of clerical expenses in the operation of doctors' offices.
3. The private practice of Radiology and Pathology.
4. Consideration of mechanisms for participation or non-participation in a government plan for insured physicians' services.
5. Review of "ground rules" to be followed in discussions with government.
6. Consideration of possible methods of implementation of a plan for Physicians' Insurance Services.
7. Application of the Fee Schedule.
8. Universal Membership.
9. The relating of the Fee Schedule to an Index.

AC12—Brief summaries of some of the above items extracted from the report are presented here: –

Item 3 – The Private Practice of Radiology and Pathology.

"At the May 27, 1967 Meeting of the Executive, the Committee was instructed to arrange a meeting with, and undertake discussions with, the Nova Scotia Hospital Insurance Commission on behalf of Radiologists and Pathologists.

The profession as a whole remains concerned about the partial loss of freedom of certain of its Sections that resulted from the acceptance of the implications of Bill 320 in 1959. In many respects, Radiologists and Pathologists in this province are trying to regain those freedoms which their confrères in Quebec are trying not to lose and, in this respect, their problems are similar.

The premise that we should negotiate with government

*AR - Annual Report
AC - Annual Council
AM - Annual Meeting
AE - Annual Executive

agencies for the practice of Radiology and Pathology, under terms and conditions similar to other medical disciplines, has been placed before the M.C.I.A.C. It is hoped that our conversations with that Commission will result in legislation which does not exclude private practice for any specialty in the proposed government plan of insured physicians' services."

Appendix B to this report (AR pages 94-95) describes in detail the approach to and the result of discussions up to November 22nd, 1967.

Item 5 – Review of Ground Rules for Participation in a Medicare Plan

The report states (AR p. 72): – "During the year, the previously formulated memoranda were reviewed with the object of listing "ground rules" which were pertinent to our discussions with government agencies.

With respect to the Fee Schedule, the following were considered important:

1. The Society reserves the right to establish and revise its own Fee Schedule.
2. The Society and the Commission must come to an agreement on the application of the Fee Schedule prior to the opening day of the plan.
3. There shall be a review of the application of the Fee Schedule at the end of one year.
4. That at intervals of not more than two years thereafter, there shall be further reviews.
5. There shall be agreement prior to the inception of the plan for the use of an Index.
6. There shall be arbitration of unresolved differences regarding Fee Schedules.
7. There will be no commitment by the Society regarding the application of the Fee Schedule until the foregoing conditions are accepted by government.

The Committee also noted the following Recommendations:

1. That the profession's representatives on the operating commission number not less than one short of the majority.
2. That a recognized method of communication between the Society and the operating commission be established.
3. That the Medical Society make the appointments or nominations to the operating commission.
4. That all physicians' services should be included as benefits in a Medicare Plan.
5. That students in this province be covered by the benefits of a Medicare Plan.

Item 6 – Consideration of Methods of Implementing A Plan for Physicians Services Insurance:

A large part of the Committee's time was devoted to consideration of methods of implementing a plan which would be acceptable to both the profession and the public. In all of these deliberations, the beliefs and policies of the profession were strongly presented in the hope that they would ultimately be projected into legislation and regulations of the Medicare Act. It has been the Society's belief that a plan, acceptable to the profession, would encourage participation on the part of physicians and, in so doing, be of increased benefit to the public it serves.

Item 7 – Application of the Fee Schedule

At the last Annual Meeting (1966), the Society accepted in principle the following items respecting its Fee Schedule and agreed that it performed three functions:

1. Provides a list of services and procedures.
2. Indicates the relative value of such services and procedures.
3. Gives a price list for such services and procedures.

It was felt that Items 1 and 3, under a Medicare Plan, could properly be matters for negotiations, but that Item 2 must remain in the hands of the profession for alteration when necessary.

Item 9 – The Relating of the Fee Schedule to an Index

The presentation of data to the M.C.I.A.C., respecting this item, was made in Memorandum # 17 last year. The Committee has made numerous references to this matter in recent months and has been assured that it is being further considered by the Commission and that it has been referred to their actuaries for an additional opinion."

AC13—Dr. Saunders moved, seconded by Dr. A. H. Shears, that the report be received for information. CARRIED.

AC14—Discussion: The desirability of "an Index", and of the privilege of "private practice" for Radiologists and Pathologists was emphasised. Dr. Stewart referred to para. AR485 of the Supplementary Report, where it was stated that N.S.H.I.C. was interposing other bodies ("paying agencies") in an effort to avoid direct discussions on this problem. He expressed the opinion that Dalhousie University would certainly not agree that N.S.H.I.C. could determine the salaries of Pathologists or Radiologists on the University Staff. Consultation of the University by N.S.H.I.C. and the Dept. of Public Health was essential.

AC 15—Dr. R. O. Jones moved, seconded by Dr. H. J. Devereux, that the report of the P.S.I. Committee be adopted. CARRIED.

AC16—Report of Maritime Medical Care Inc.: (AR p.36-38) President, Dr. H. B. Whitman, Maritime Medical Care Inc.

The report, reviewing the past year, noted that enrollment had increased from 192,000 to 211,000, that 60,000 (compared with 46,000) were enrolled in the Supplementary Hospital Benefit Plan and that the Extended Health Benefit Plan covered 33,000 (compared with 23,000 in the previous year).

AC17—Referring to insured services provided by physicians, it was noted that no items remained on "the negotiated list" as a result of a resolution from the Meeting of Council 1965. Payments to physicians had been increased from 85% to 90% of the Schedule. The 1967 Schedule of Fees had been accepted as a basis for payment to physicians on and after October 1, 1967. There are 791 participating physicians in Nova Scotia. He reported that because of these changes the premiums for subscribers had been increased by approximately 33%: this had been the only increase since 1959.

AC18—The report included the following statement (AR p. 37-38): –

"The highlight of 1967 for M.M.C. was the signing of an agreement between the Corporation and the Province of Nova Scotia providing for the use of M.M.C.'s administrative facilities in the operation of the Province's proposed Medicare plan. The terms of the agreement were reported to the Executive Committee of the Medical Society at the Summer Meeting.

Briefly, the arrangement provides that all policy matters respecting Medicare will be the exclusive domain of the Province's Medical Care Insurance Commission. Decisions relating to the amount and method of reimbursement to physicians, the range of benefits under Medicare, and method of raising the necessary funds to pay for the plan are matters which will be within the jurisdiction of

the Province and the Commission. M.M.C. will merely provide the personnel and facilities to carry out the Commission's policy decisions. The administrative arrangement for Medicare will be jointly designed by M.M.C. and the Province's Division of Administrative Services, subject of course to final approval by the Commission.

The Province has agreed that M.M.C. may continue to provide voluntary non-profit programs of health insurance for those health supplies and services which will not be benefits under Medicare. The Corporation will absorb the full cost of operating and underwriting such private plans.

The Corporation's Board structure will be changed to provide for five Directors to be appointed by Governor in Council, replacing our present five non-medical Directors, and the Halifax and Cape Breton Branch Society representation on the Board will be reduced from two to one member each.

As part of its duties M.M.C. will: –

1. Assess and pay claims in accordance with the policies and procedures prescribed by the Commission;
2. Participate in the design and application of utilization statistics and controls;
3. Participate in determination of the eligibility of a resident for insured services under the Plan;
4. It is agreed that M.M.C. will be the custodian of confidential clinical information respecting residents.

It has been agreed that the Corporation's existing appeal and claims review procedures will be retained including the use of M.M.C.'s Taxing, Medical Advisory and Executive Committees. Both physician and resident will, however, have final recourse to the Commission.

With respect to the reimbursement of M.M.C. for the administration of the Plan, it has been agreed that the Corporation will be paid for the actual cost of operating the Medical Care Plan under a general principle of neither profit nor loss to the Corporation.

M.M.C. is pleased to have been selected to serve in this capacity and is satisfied with the agreement that has been negotiated."

AC19—Dr. Whitman moved, seconded by Dr. A. J. M. Griffiths, that this report be accepted for information. CARRIED.

AC20—**Discussion:** Dr. Norman Glen referred to Para. AR124 and objected to the statement; "Both physician and resident will, however, have final recourse to the Commission." This lead to resolution AC'67 # 1:

AC'67 # 1: –

Moved by Dr. N. Glen

Seconded by Dr. E. Ryan.

"THAT the last sentence of Para. AR124 be changed to read "Both physician and resident will, however, have recourse to the Commission and Courts." CARRIED.

AC21—Further discussion resulted in a vote of thanks to Mr. Brannan, General Manager and Dr. A. W. Titus, Medical Director, of M.M.C. Inc.

AC'67 # 4: –

Moved by Dr. J. H. Charman.

Seconded by Dr. H. J. Devereux.

"THAT a formal vote of thanks to Dr. A. W. Titus for his efforts in drawing up an Alphabetical Index for the revised Fee Schedule (1967) be passed by this Society." CARRIED.

AC22—**Committee on Medical Economics:** (AR p. 13-15) Chairman, Dr. K. B. Shephard.

The report indicated the Committee had been engaged in the following activities:

(1) Continuation of negotiations with the Department of Public Welfare for the up-grading of the amount of money available for the payment of physician's services to those identified under the "Welfare Contract".

(2) Extension of the benefit range for those identified in the above group.

(3) Submission of a brief and petition to the Minister of Public Welfare to have that department assume financial responsibility for medical examinations for Social Assistance and Dependent Persons Allowance.

(4) Continuation of a dialogue on economic problems with the Executive of The Medical Society of Nova Scotia and the C.M.A. Committee on Medical Economics.

AC23—In April 1966, the number of beneficiaries under the Welfare Agreement had been 9,692 which has increased to 20,241 as of September 1967. It was noted that a deficit position for the group had developed starting in June 1967 due to the inclusion of "high risk" groups resulting in increased utilization. The financial aspect, which includes the application of the 1967 Schedule, is under review with the Department of Public Welfare. It is also noted that there has been an increase in the benefit range of insured physicians' services. A mutually satisfactory arrangement has been developed between the Committee and the Department while gathering experience as to demand for physicians' services.

AC24—A summary of the work with the CMA Committee on Medical Economics is listed as: –

"(a) Joint sponsorship CMA-TCMP Conference Economics Medical Manpower, Montreal, June 1967. This important conference has served to update information and establish a more widely understood consensus of problems of the present. The future was examined and guideposts suggested.

(b) Recommended recognition of alcoholism as a recompensible disease by medical care insurance programmes.

(c) CMA and TCMP are to study problem areas in existing fee schedules and make suggestions for possible improvements.

(d) That consideration be given to establishment of an Economic Health Research Foundation in conjunction with TCMP – approved by General Council.

(e) Studies on fee schedules, professional expenses, remuneration of interns and residents, professional hospital funds and their distribution, remuneration of physicians in special or extraordinary circumstances, have been initiated and will continue."

AC25—Discussion of these items resulted in the following Resolutions: –

AC'67 # 2:

Moved by Dr. K. B. Shephard.

Seconded by Dr. D. C. Cantelope.

"THAT the Society urge hospitals in Nova Scotia, retaining interns, to pay a salary to interns of not less than $300. per month, plus full maintenance, that this stipend be reviewed annually with The Medical Society of Nova Scotia and that the Nova Scotia Hospital Insurance Commission be urged to support this principle." CARRIED.

AC'67 # 3:

Moved by Dr. S. C. Robinson.

Seconded by Dr. C. L. Gosse.

"THAT whereas The Medical Society of Nova is concerned with the income of salaried physicians, THEREFORE, be it resolved that the Committee on Fees be requested to study the salaries of hospital residents, and report to the Executive Committee." CARRIED.

AC26—Committee on Fees: (AR p. 10) Chairman, Dr. J. H. Charman.

Dr. Charman reviewed his report and moved, seconded by Dr. J. A. Smith, that it be accepted for information. CARRIED.

AC27—The Chairman of Council, Dr. Saunders, introduced a resolution from the Annual Meeting of the Executive Committee Meeting, AE'67 # 2:

AE'67 # 2:

Moved by Dr. G. McK. Saunders.

Seconded by Dr. A. J. M. Griffiths.

"THAT the first sentence of AR76 (Annual Report of Committee on Fees) be amended to read "any agreement with Government should include the right of the Society to revise its Fee Schedule at regular agreed intervals." CARRIED.

AC28—This resolution was approved by Council after discussion about the period of time between these reviews. The suggestion that this period should not exceed two years appeared to be satisfactory. The composition of the 2nd sentence in para. AR 76, which reads, "This revision could be based on a composite cost of living index" resulted in a motion by Dr. Charman and seconded by Dr. Still that this sentence be amended to read "This revision should be based on a composite index".

AC29—A vote of thanks was extended to Dr. Charman and his Committee members.

AC30—Committee on Hospitals: (AR p. 59-60) Chairman, Dr. J. A. Smith.

The report was presented by Dr. Smith. It gave a comprehensive review of a meeting of the C.M.A. Committee on Hospitals. A motion by Dr. J. A. Smith, seconded by Dr. Grantmyre, that the report be accepted for information as carried.

AC31—Discussion: Dr. Robinson spoke in favour of the report and introduced a resolution, AE'67 #7 from the Executive Committee as an amendment: –

AE'67 # 7:

Moved by Dr. J. B. Tompkins.

Seconded by Dr. J. B. MacDonald.

"THAT the Executive Committee recommends to Council the desirability of elected representatives of the Medical Staff to Hospital Boards with full voting privileges. This is in accordance with the C.M.A. Committee on Hospitals and hospitals should be notified accordingly and the reasons for this request be outlined." CARRIED.

On motion by Dr. S. C. Robinson, seconded by Dr. Glen, the proposed amendment was approved.

AC32—Dr. C. B. Stewart suggested that the Hospital Committee consider recommending to hospitals the establishment of a Staff Health Committee. Discussion on this resulted in:–

Resolution AC'67 # 30:

Moved by Dr. C. B. Stewart.

Seconded by Dr. D. C. Cantelope.

"THAT the Committee on Hospitals consider the desirability of recommending to hospitals the establishment of a Committee on Staff Health." CARRIED.

AC33—Liaison Committee with the Nova Scotia Hospital Association: (AR p. 61-65), Chairman, Dr. J. A. Smith.

The report was presented by Dr. Smith who moved, seconded by Dr. Grantmyre, that it be accepted for information. CARRIED.

AC34—The report summarized the experience of the Committee in discussion at the Nova Scotia Hospital Association and with the Nova Scotia Hospital Insurance Commission (including the "paying agencies") relative to remuneration of Pathologists and Radiologists under the Hospital Insurance Act.

AC35—Para AR313—

"The foregoing summary was presented to the Executive on May 27, 1967. We concurred with the request of the Section for Radiology and the Executive Committee decision that all negotiations on behalf of Medicine should be done by one body, and accordingly the matter was turned over to the P.S.I. Committee who are deeply involved in negotiations and discussions with government on the broad front of Medical Care Insurance."

This was discussed and approved.

AC36—The Committee recommended (AR318) that, "This Liaison Committee could now well be abolished as all liaison with the Nova Scotia Hospital Association could quite properly be done by the Committee on Hospitals.". It was moved by Dr. Grantmyre and seconded by Dr. D. R. MacInnis, that this recommendation be adopted. CARRIED.

AC37—Report of Workmen's Compensation Board Liaison Committee: (AR p. 30)

Chairman, Dr. M. E. DeLory.

The report was presented by Dr. DeLory who moved that it be accepted for information, seconded by Dr. Tompkins.

AC38—Discussion: Para AR195, "As in the past, the Workmen's Compensation Board continues to be under the impression that it is our privilege to treat their patients.", resulted in considerable discussion and Resolution AC'67 # 5: –

AC'67 # 5:

Moved by Dr. C. L. Gosse.

Seconded by Dr. J. Purves.

"THAT Para AR195 be deleted from the report of the Workmen's Compensation Board Liaison Committee." REJECTED.

AC39—Resolution AE'67 #4, from the Annual Meeting of the Executive Committee was introduced: –

AE'67 # 4:

Moved by Dr. N. G. Glen.

Seconded by Dr. D. J. G. Morris.

"THAT whereas relationships between the Medical Profession of Nova Scotia and the Workmen's Compensation Board of Nova Scotia have been unsatisfactory for a number of years;

and WHEREAS para AR192 in the Annual Report of this Committee states, "..... explanation and understanding of the decisions taken by the Workmen's Compensation Board has been very discouraging because the correspondence with the Workmen's Compensation Board has been very emphatic leaving no room for negotiation,

and WHEREAS, our Workmen's Compensation Board Liaison Committee has made no recommendation towards improving the situation: –

BE IT RESOLVED that the Executive Committee express its disappointment with this continuing unsatisfactory relationship and invites constructive suggestions from Council." CARRIED.

This resolution was, on motion, **approved** by Council.

AC41—**Report of Committee on Accommodation for Offices of the Medical Society:** (AR p. 31), Chairman, Dr. C. L. Gosse.

Dr. Gosse reported that the Society had moved into the new accommodation on the 15th Floor of the Sir Charles Tupper Building in September 1967; the preparation of the space provided by the University had been finished with the cost reasonably near the budget approved by the Society. It was noted that the Executive Committee had already expressed the appreciation of the Society to Dean Stewart. This action was sincerely endorsed by Council.

AC42—No New Business was asked for and no Other Business brought up. The 1st Session of Council was adjourned at 12.15 p.m. to be re-convened as a Committee of the whole to consider the report of the Committee on the Secretariat, Chairman, Dr. F. G. Mack. Members of the Secretariat were requested to retire during this discussion.

SECOND SESSION OF COUNCIL

AC43—The 2nd Session of Council was convened by the Chairman, Dr. G. MacK. Saunders, at 2.45 p.m. The presentation of Reports of Committees was continued.

AC44—**Committee on Finance:** (AR p. 47-54) Chairman, Dr. C. D. Vair, Honorary Treasurer.

The report included the Financial Statement for the year ending December 31, 1966, Dr. Vair moved, seconded by Dr. Myrden, that the report be received for information. CARRIED.

AC45—Resolution AE'67 #5 from the Executive Committee was then introduced: –

AE'67 # 5:

Moved by Dr. F. G. Mack.

Seconded by Dr. J. B. MacDonald.

"THAT whereas the present Executive Secretary Dr. C. J. W. Beckwith, by reason of ill health, is unable to continue to function in his present capacity and

WHEREAS, the appointment of a new Executive Secretary is necessary, and

WHEREAS, The Medical Society of Nova Scotia wishes to recognize the loyal services of Dr. Beckwith to the Society in the past 11 years and to avail itself of his knowledge and advice in Society matters in the future,

THAT, on the appointment of a new Executive Secretary, Dr. Beckwith be made a Consultant to The Medical Society of Nova Scotia at an annual Honorarium of $5,000., and that dues be adjusted to meet this commitment."

CARRIED.

AC46—The above resolution was, on motion, **approved** by Council.

AC 47—The increase in dues made necessary by the above resolution resulted in the following motion: –

AC'67 # 6:

Moved by Dr. C. D. Vair.

Seconded by Dr. S. C. Robinson.

"THAT the incoming Finance Committee be given the authority, if necessary, to increase the dues of The Medical Society of Nova Scotia for the year 1968 substantially to cover the additional expenses of obtaining a new Executive Secretary and for retaining our present Executive Secretary in the capacity of a Consultant to The Medical Society of Nova Scotia." CARRIED.

AC48—**Committee on Membership:** (AR p. 57-58), Chairman, Dr. M. G. Tompkins.

Dr. Tompkins moved, seconded by Dr. Devereux, that the report be accepted for information. Following discussion, it was agreed that consideration of the report of the Committee on Legislation & Ethics follow that of the Committee on Membership.

AC49—Dr. Tompkins' report included an analysis of membership according to classification and a review of the number of members over the past 5 years. The report stated that his Committee had been requested by the Executive Committee to study and make recommendations relative to Universal Membership in The Medical Society of Nova Scotia, resulting in the Resolution (Para AR273) from his Committee. This resolution reads: –

"That membership in The Medical Society of Nova Scotia be compulsory for all licensed physicians resident in Nova Scotia."

AC50—Resolution AE'67 #6 from the Annual Meeting of the Executive was introduced, namely: –

AE'67 # 6:

Moved by Dr. N. Glen.

Seconded by Dr. F. Markus.

"THAT the Executive Committee concurs with the Resolution in Para AR273 and recommends its adoption by Council." CARRIED.

AC51—During discussion of this resolution, Dr. MacPhail stated that he had spoken against Resolution AE'67 #6 at the Meeting of the Executive, expressing the view that the physicians who are not members might be enticed to join. Dr. Gorman expressed the view that all physicians in Nova Scotia should be members of the Society and suggested that a condition of licensing for practice in Nova Scotia by the Provincial Medical Board be that a physician show evidence that he is a member in good standing of The Medical Society of Nova Scotia.

AC52—Dr. Griffiths suggested that the report of the Committee on Legislation & Ethics now be considered. This was accepted by Council.

AC53—**Committee on Legislation & Ethics:** (AR p. 12 & Supplementary Report p. 85-86).

Chairman, Dr. H. K. Hall.

Dr. Hall moved, seconded by Dr. Smith, that paras. AR165-167 be accepted for information. CARRIED.

AC54—The Supplementary Report included recommendations relative to the Medical Act. Dr. Hall proposed that the recommendations in para. AR429-433 be discussed, that paras. AR434-438 be received for information and that paras. AR439-443, also being recommendations, be discussed. This approach was approved by Council.

AC55—Para AR429 recommended that: –

"The Provincial Medical Board, as the regulatory body, should be an organization that remains separate and apart from The Medical Society of Nova Scotia."

AC56—**Discussion:** – Dr. Gorman requested a definition of 'regulatory body' observing that it is advisable to keep the Society separate from a 'regulatory body'. Additional discussion included the subject of Universal Membership in relation to the Medical Act. Dr. Hall expressed the opinion that the Medical Act is basically a guarantee to the public that good care will be received from a physician. Further discussion resulted in Resolution AC'67 # 8: –

AC'67 # 8:

Moved by Dr. H. J. Bland.

Seconded by Dr. T. Gorman.

"THAT Para. AR429 read 'The Provincial Medical Board as the Statutory Regulatory Body, should be an organization that remains separate and apart from The Medical Society of Nova Scotia'." CARRIED.

AC57—Para. AR430 recommended that "The Medical Board, should consist of 13 qualified practitioners of not less than 7 years standing, 2 to be appointed by the Governor in Council, 2 by the Senate of Dalhousie University from active members of the Faculty of Medicine, 2 by the Medical Society, and 7 elected by the qualified medical practitioners who have resided in Nova Scotia for more than 1 year. As far as is possible, these seven members would represent geographical areas."

AC58—Dr. Robinson expressed the opinion that there should be an amendment to the wording of Para. AR 430 which resulted in Resolution AC'67 # 9: –

AC'67 # 9:
Moved by Dr. S. C. Robinson
Seconded by Dr. A. Shears.
"THAT in Para. AR430, the words 'two by the senate of Dalhousie University' be altered to read 'two by the Council of the Faculty of Medicine of Dalhousie University'." REJECTED.

AC59—Additional discussion resulted in Resolution AC'67 # 10: –

AC'67 # 10:
Moved by Dr. C. L. Gosse
Seconded by Dr. J. B. Tompkins
"THAT Para. AR430, line 3, be amended to read 'two by Dalhousie University on the recommendation of the Faculty of Medicine'." CARRIED.

AC60—Dr. Devereux asked what method would be used to elect the "seven members elected by qualified medical practitioners", and asked for consideration of what points the Society could put forward to convince the Government to give up their right to appoint the majority on the Medical Board as is now the case. Dr. Ian Maxwell suggested that the process of electing the seven to the Provincial Medical Board should be specifically outlined. Dr. Wickwire expressed the belief that the seven should be elected by the Medical Society rather than being appointed by Government. The discussion resulted in Resolution AC'67 # 11: –

AC'67 # 11:
Moved by Dr. C. L. Gosse
Seconded by Dr. M. W. O'Brien
"THAT Para. AR430, as amended, be referred back to the Committee for further clarification and rewording." CARRIED.

AC61—During discussion on that resolution, a member suggested that the wording should include something regarding the tenure of office of the members.

AC62—Para. AR431 recommended that "Provision should be made to permit annual grants for Postgraduate Education, sufficiently large to cover the costs of bringing the continuing education programme of the Postgraduate Division of the Faculty of Medicine and The Medical Society of Nova Scotia to all physicians residing in Nova Scotia." On motion, Para. AR431 was approved.

AC63—Para. AR432 recommended that "Provision should be made for annual licensing and annual fees. Recognizing The Medical Society of Nova Scotia to be an indispensable organization of provincial Medicine, it is proposed that the Act be modified to require every qualified practitioner who resides in Nova Scotia, and whose name appears on the Register, to submit a receipt from The Medical Society of Nova Scotia for dues to that Society for the ensuing year, together with the annual registration fee payable to the Board. The dues payable to the Society by a qualified medical practitioner who did not wish to be an active member of the Society, or whom the Society did not wish to have as an active member, should be sufficient to indemnify the Society for its activities which benefit the profession as a whole, but should not include a contribution toward activities carried out solely for the benefit of its active members. The amount of dues for these activities would be approved by the Board who would have access to audited financial statements from the Society. Fees would be for the calendar year."

AC64—**Discussion:** Resulted in Resolution AC'67 # 14: –

AC'67 # 14:
Moved by Dr. K. B. Shephard
Seconded by Dr. B. F. Reid
"THAT this meeting accept Para. AR432 as a preliminary expression of opinion of the Committee on Legislation & Ethics." CARRIED.

AC65—Para AR433 recommended that
"Section 9(1) (c) (of the Medical Act) should be amended because of the present inability of the Board to control the qualification and the professional standards of registrants entering under this Section of the Act. Consequently, it is recommended that the Provincial Medical Board take steps to limit and control the present reciprocity agreement and to insure that the individuals concerned are competent in the areas of Medicine in which they intend to practice."

AC66—During discussion, Dr. Griffiths introduced Resolution AE'67 # 3 from the Annual Executive Committee Meeting: —

AE'67 # 3:
Moved by Dr. A. J. M. Griffiths
Seconded by Dr. N. Glen
"THAT (1) the Executive Committee recommend to Council Para AR433 be approved for early action by the Provincial Medical Board;
(2) that the remainder of the Report of the Committee on Legislation and Ethics be referred back for study;
(3) that the Provincial Government be asked to establish a Commission to examine the Medical Act and make recommendations after receiving submissions from interested parties." CARRIED.

AC67—Further discussion resulted in Resolution AC'67 # 12: —

AC'67 # 12:
Moved by Dr. A. J. M. Griffiths
Seconded by Dr. S. C. Robinson
"THAT Para AR433 be approved for early action by the Provincial Medical Board." CARRIED.

AC68—During discussion of the foregoing resolution, a member asked whether the Provincial Medical Act would be re-written this year. A member from the Provincial Medical Board felt it was too late to provide the necessary study to rewrite the Act this year, but that it would be rewritten next year (1968-69) and that the recommendations of the Society would be considered at that time.

AC69—Resolution AC'67 # 13 was presented.

AC'67 # 13:
Moved by Dr. A. J. M. Griffiths
Seconded by Dr. J. A. Smith
"THAT the remainder of the report of the Committee on Legislation & Ethics be referred back for study." DEFEATED.

AC70—Dr. W. C. O'Brien moved, seconded by Dr. R. Weil, that Paras, AR434 to AR438 be accepted for information.

AC71—Para AR439 recommended that

"Insuring agencies be required to report to the Provincial Medical Board, the name of any physician from whom they have received what they consider to be false or fraudulent claims."

AC72—Discussion resulted in AC'67 # 15:—

AC'67 # 15:

Moved by Dr. S. C. Robinson

Seconded by Dr. A. J. M. Griffiths

"THAT Para AR439 be amended to delete the words 'what they consider to be'." REJECTED.

AC73—Dr. Devereux expressed the opinion that this phrase should not be included and that it should be rewritten.

AC74—Para. AR440 **recommended**

"The Board should have authority to suspend the license of a physician who is, by reason of physical or mental infirmity, unable to carry on the practice of medicine with competence."

AC75—Discussion resulted in Resolution AC'67 # 16:—

AC'67 # 16:

Moved by Dr. R. O. Jones

Seconded by Dr. E. Ryan

"THAT Para. AR440 be amended by deleting 'by reason of physical or mental incompetence'." CARRIED.

Para AR440 now reads

"The Board should have the authority to suspend the license of a physician who is unable to carry on the practice of medicine with competence."

AC76—Para AR441 recommended

"It is our belief that the Board should, under certain circumstances, have investigative authority. Such action should be possible when the Board has been supplied with information by certain responsible bodies of Government or organized Medicine."

AC77—Discussion resulted in Resolution AC'67 # 17:—

AC'67 # 17:

Moved by Dr. C. L. Gosse

Seconded by Dr. D. R. MacInnis

"THAT in Para AR441, the last sentence be deleted." CARRIED.

Para AR441 will now read:

"It is our belief that the Board should, under certain circumstances, have investigative authority."

AC78—Para AR442 recommended: -

"Interim licensing should be provided for well-qualified graduates of acceptable foreign medical schools while they are awaiting an opportunity to write their L.M.C.C. examinations. Such license would apply for a one-year period."

AC79—Para AR443 reads

"We recommend that the Board consider methods of ensuring continuing proficiency of its registrants by such means as examinations or the production of evidence of attendance for a certain number of hours of post-graduate education per year. Since this is such a contentious issue, we wish an expression of opinion on this matter from members of the Society."

AC80—Following a lengthy discussion, Resolution AC'67 # 18 followed: -

AC'67 # 18:

Moved by Dr. C. E. Kinley

Seconded by Dr. J. Purves

"THAT Para AR443 be amended to read 'We recommend that the Provincial Medical Board consider methods of insuring continuing proficiency of its registrants by establishing joint study groups with the Post Graduate Division of the Faculty of Medicine, the Medical Education Committee of the Medical Society of Nova Scotia and the College of General Practice (Family Practitioners)'." CARRIED.

AC81—Resolution AC'67 # 19 was presented: -

AC'67 # 19:

Moved by Dr. A. J. M. Griffiths

Seconded by Dr. S. C. Robinson

"THAT the Provincial Government be asked to establish a Commission to examine the Medical Act and make recommendations after receiving submissions from interested parties." CARRIED.

AC82—The Chairman, Dr. Saunders, then asked Council to consider the Resolution included in the Report of the Committee on Membership. This resulted in Resolution AC'67 # 20: -

AC'67 # 20:

Moved by Dr. J. B. Tompkins

Seconded by Dr. T. W. Gorman

"THAT Para AR273 namely, 'membership in The Medical Sociey of Nova Scotia be compulsory for all licensed physicians in Nova Scotia', be approved." CARRIED.

AC83—No New Business was asked for, and no other business brought up. The Second Session of Council was adjourned at 5 45 p.m.

THIRD SESSION OF COUNCIL

AC84—The 3rd Session of Council was convened by the Chairman, Dr. G. McK. Saunders, at 9.45 a.m., Saturday, November 25th. The review of Reports of Committees was continued.

AC85—**Committee on By-Laws: -** (AR p. 90 & 98) Chairman, Dr. J. E. Hiltz

Dr. Hiltz presented his report, stating that the Supplementary Report on page 98 was not intended as such but as a communication to the Executive Secretary. He requested that it be withdrawn from the reports. Dr. Hiltz moved, seconded by Dr. Devereux, that the report be received for information.

AC86—Dr. Hiltz then moved that paragraphs AR467 and AR468 be adopted. These paras. referred to the September 1967 issue of the Bulletin, which carried a notice of motion that Chapter IX, "Composition of Council" be changed to include "Members of the Society who are members of the General Council of the Canadian Medical Association and also to include the Dean of Medicine as a Member."

AC87—Further discussion resulted in Resolution AC'67 # 21: -

AC'67 # 21:

Moved by Dr. J. E. Hiltz

Seconded by Dr. S. C. Robinson

"THAT the suggested amendment to Chapter XII of the By-Laws ("Committees"), which would make the President-Elect a member of the Nominating Committee, should be given further consideration by the Executive Committee." CARRIED.

AC88—**Report of the Editorial Board - Nova Scotia Medical Bulletin** (AR p. 55-56) Chairman, Dr. Ian E. Purkis.

Dr. Purkis reported that the Editorial Board of the Bulletin had had a disappointing year because of a deficit

position resulting from decreasing revenues and increasing costs, but that the deficit should be accepted as a necessary accompaniment of a high quality bulletin, if it is to carry out its proper function. On motion, the report was accepted for information.

AC89 Recommendations:

(1) (Para AR269) "THAT The Medical Society upholds the principle of publishing a high quality bulletin as an instrument of post-graduate education.

Moved for adoption by Dr. Purkis, seconded by Dr. R. O. Jones. CARRIED.

(2) (Para AR270) "THAT the appointment of advertising salesman be continued on the present basis."

Moved for adoption by Dr. Purkis, seconded by Dr. E. Ryan. CARRIED.

(3) (Para AR271) "THAT deficits incurred in the operation of the journal continue to be underwritten by the Society."

Moved for adoption by Dr. Purkis, seconded by Dr. A. H. Shears. CARRIED.

AC90—Committee on Medical Education (AR p. 16) - Chairman, Dr. R. N. Anderson.

Having presented his report, Dr. Anderson moved that paras. AR231-233 be accepted for information.

AC91—Recommendations: paras. AR234, 235 & 236 were considered individually.

Recommendation No. 1 (AR234)

"THAT this society explore all aspects of the problem of quality of medical care in order that a clear stand may be taken on the issue."

Motion for adoption. CARRIED.

Recommendation No. 2 (AR235)

"THAT this society adopt a policy of support in principle for the development of family practice units by Medical Schools in conjunction with Teaching Hospitals."

A member asked for clarification of the wording "in conjunction with teaching hospitals." Dr. Anderson stated that it was planned to develop a model family practice unit where students would have the advantage of such family practice units. On motion, this recommendation was CARRIED.

Recommendation No. 3 (AR 236)

"That the Faculty of Medicine of Dalhousie be informed of this policy."

On motion, this recommendation was adopted.

AC92—Committee on Maternal & Perinatal Health (AR p. 79-84) Chairman, Dr. D. F. Smith.

Dr. Smith presented his report and moved, seconded by Dr. B. S. Morton, that it be accepted for information. Dr. Smith noted that his Annual Report only included the maternal aspects of the Committee work and the report on perinatal health was not included as it consisted of 23 pages. He gave a summary of the perinatal report. The following resolutions were presented during the ensuing discussion.

AC93 Resolution: -

AC'67 # 22:

Moved by Dr. D. F. Smith

Seconded by Dr. D. R. MacInnis

"THAT The Medical Society of Nova Scotia support the plan as outlined, as a basis for definite proposals to the Nova Scotia Hospital Insurance Commission concerning the setting up of facilities in each of the designated high risk hospitals. In order to do this, it would be necessary for us to use information collected by this Committee concerning total births, prematures and neonatal deaths in the various hospitals. This information has already been collected independently by the Dept. of Public Health so confidences are not broken." CARRIED

AC94—Dr. Smith expressed the view that the work being done in the interest of maternal health was being slowed down because of the amount of time devoted to perinatal health. Dr. Smith proposed Resolution AC'67 # 23: -

AC'67 # 23:

Moved by Dr. D. F. Smith

Seconded by Dr. B. Morton

"THAT the present Committee on Maternal and Perinatal Health of The Medical Society of Nova Scotia be divided into two separate committees; namely, the Committee on Maternal Health and the Committee on Perinatal Health." CARRIED.

AC95—Dr. Smith urged that each hospital in the region set up a Committee of Review of Perinatal Mortality, resulting in Resolution AC'67 # 24: -

AC'67 # 24:

Moved by Dr. D. F. Smith

Seconded by Dr. G. Davis

"THAT whereas, for the past 8 years, all perinatal mortality in the Halifax-Dartmouth area has been reviewed in depth by this committee, and that such a critical analysis has helped to reduce the perinatal mortality in the 'Atlantic Region' and,

WHEREAS, the two Halifax obstetrical hospitals will be setting up individual Review Committees in the future to continue this evaluation of perinatal results,

Therefore, it is moved that, each hospital or each region in Nova Scotia where obstetrical care is given be strongly advised to set up a committee to regularly review and analyze perinatal deaths, and that this review be presented to the hospital staffs." CARRIED.

AC96—Committee on Child Health (AR p. 6-9) Chairman, Dr. B. S. Morton.

The report included remarks on: -

1. The Rh Project (Para AR213),
2. Measles Vaccination (Para AR215)
3. Intensive Care Nurseries (Para AR216)
4. Sudden Death in Infancy (Para AR217)
5. Accident Prevention (Para AR222)

Dr. Morton moved, seconded by Dr. D. F. Smith, that paras. AR212 - AR227 be received for information. CARRIED.

AC97—Recommendations: The three recommendations were considered individually as follows: -

Recommendation (AR228)

"WHEREAS live attenuated measles virus vaccine has proven effective in the prevention of measles.

BE IT RESOLVED THAT this Committee recommend the use of live attenuated measles virus vaccine in routine immunization of all susceptible age groups of 12 months or over, except when the live virus vaccine is contraindicated."

Discussion resulted in Resolution AC'67 # 25 : -

AC'67 # 25:

Moved by Dr. B. S. Morton

Seconded by Dr. J. A. MacPhail

"THAT Recommendation No. 1 (AR228) be adopted." CARRIED.

Recommendation 2 (AR229):

"WHEREAS sudden death in infancy remains a major

problem, the extent of which is unknown, and the cause unexplained in a large percentage of cases.

BE IT RESOLVED THAT in all cases of sudden death in infancy, whether at home or in hospital:

(1) an autopsy be performed in a recognized Dept. of Pathology.

(2) An adequate history of the pertinent circumstances surrounding the death be recorded at the time of the incident and,

(3) if the cause of death is not adequately explained by history and /or autopsy that this should be so recorded in the death certificate (as International Classification No. 795, which is "ill-defined and unknown causes").

Discussion resulted in Resolution AC'67 # 26: -

AC'67 # 26:

Moved by Dr. B. S. Morton

Seconded by Dr. S. C. Robinson

"THAT Para AR229 (Recommendation No. 2) be adopted with the addition of the words 'and that this resolution be forwarded to the Attorney General's Dept.' " CARRIED.

Recommendation 3 (AR230):

"WHEREAS it is stated in the Dominion Bureau of Statistics Report on Accident Mortality for the years 1950-1964 that the Canadian rate is amongst the highest known in the world for under-five age group:

BE IT RESOLVED THAT physicians be encouraged to concentrate on accident prevention education of families under their care."

A discussion resulted in Resolution AC'67 # 27: -

AC'67 # 27:

Moved by Dr. B. S. Morton

Seconded by Dr. H. C. Still

"That Recommendation No. 3 (Para AR230) be adopted. CARRIED.

AC98—Committee on Cancer (AR p. 66-67) Chairman, Dr. J. A. Myrden.

Dr. Myrden expanded on several of the paragraphs in his report. The Summary of the report (AR331-AR333) states: -

AR331: (1) "Uterine Cancer Detection Programme continues to show increase in the number of cytological examinations performed, and the incidence of invasive carcinoma of the cervix shifting from Stage 4 to Stage 1."

AR332: (2) "The Provincial Cancer Registry continues to function satisfactorily, and is receiving excellent cooperation in the reporting of malignancies by the medical profession."

AR333: (3) Programmes of the Nova Scotia Division, Canadian Cancer Society are outlined, and your Committee asks the continuing support of the medical profession in the work of this organization."

AC99—Dr. Myrden moved, seconded by Dr. G. E. Davis, that paras. AR319-AR333 be accepted for information. CARRIED.

AC100—Dr. Myrden moved, seconded by Dr. G. E. Davis, that the recommendation in Para. AR 334 be adopted. CARRIED. The recommendation reads: -

"The National Cancer Committee of the Canadian Medical Association be asked to have a meeting of this Committee during the coming year."

AC101—Committee on Committee Structure (AR p. 101) Chairman, Dr. D. C. Cantelope.

This report was distributed by Dr. Cantelope to members of Council on Saturday morning. Dr. Cantelope then read his report to Council. The report consisted of nine recommendations from the Committee. Each was discussed.

AC102—Recommendation No. 1: - "The Chairman of the Medical Economics Committee should be a member of the Committee on Fees." Moved for adoption by Dr. Cantelope, seconded by Dr. Morris. CARRIED.

AC103—Recommendation No. 2: - "The P.S.I. Committee be made up of the President of the Society, Past-President, President-Elect and 4 others." Moved for adoption by Dr. Cantelope, seconded by Dr. Taylor. CARRIED.

AC 104—Recommendation No. 3: - "The Joint Study Committee (Medical Society of Nova Scotia and Maritime Medical Care) be dropped from the Committee Structure." Moved for adoption by Dr. Cantelope, seconded by Dr. Dunsworth. CARRIED.

AC105—Recommendation No. 4: - "The functions of the Federal Health Grant Committee be a duty of the Executive Secretary." Moved for adoption by Dr. Cantelope, seconded by Dr. C. B. Stewart. CARRIED.

AC106—Recommendation No. 5: - "The Chairman of the Executive Committee and the Chairman of Council be the same individual and that this matter be referred to the Committee on By-Laws." Dr. Cantelope moved that this be adopted, seconded by Dr. R. O. Jones.

AC107—Discussion. During discussion of this motion, it was questioned whether Council should make the change or if it should be referred to the Committee on By-Laws. A motion for **referral** to the Committee on By-Laws was CARRIED.

AC108—Recommendation No. 6: - "The Liaison Committee with the Nova Scotia Hospital Association be discontinued and its duties taken over by the Committee on Hospitals." Dr. Cantelope moved, seconded by Dr. E. Ryan, that recommendation No. 6 be adopted. CARRIED.

AC109—Recommendation No. 7: - "Many Committees should be represented only by a Chairman, who is a member of the corresponding C.M.A. Committee. He should have the authority to form a local committee only if necessary to work on any obvious local project." It was moved by Dr. Cantelope, seconded by Dr. Purves, for adoption. During discussion several members expressed concern about the recommendation No. 7, resulting in a motion for **referral** back to the Committee, which was CARRIED.

AC110—Recommendation No. 8: - "Thought should be given to try to have the Executive Committee elected more on a 'representation by population' basis than on a 'regional branch society' basis. The Executive should not become too large (12-14 members only)." Dr. Cantelope moved, seconded by Dr. F. G. Bell. After some discussion, it was moved by Dr. Dunsworth and seconded by Dr. MacPhail that recommendation No. 8 be **referred** back to the Committee for study. CARRIED.

AC111—Recommendation No. 9: - "That this Committee on Committee Structure be a continuing Committee." This was moved for adoption by Dr. Cantelope, seconded by Dr. S. C. Robinson. CARRIED.

AC112—Committee on Traffic Accidents (AR p. 28-29) Chairman, Dr. J. F. Ross.

The report was presented under 5 headings: -

1. Para AR184 - "Legislative Committee
2. Para AR185—"Helmets for Motor Cycle Drivers"
3. Para AR186—"Ambulances"
4. Para AR187—"Breathalizer Tests"
5. Para AR188—"Driver Training"
6. Para AR189—"Trauma Team"

Dr. Ross moved, seconded by Dr. D. F. Smith, that the report be received for information. CARRIED.

AC113—Discussion: - Dr. Ross noted that the first sentence of Para AR187 should read: "A recent court case indicates that the Breathalizer Test has been used in court for the first time in Nova Scotia", and that the last sentence of this same para should read: "It is hoped that once the Breathalizer Test has been accepted, the level of 0.1gm% will be cut down to 0.08gm.% or even as low as 0.05 gm%.

AC114—Para AR186, dealing with Ambulance Service, was discussed briefly, resulting in Resolution AC'67 # 29: -

AC'67 # 29:

Moved by Dr. C. E. Kinley

Seconded by Dr. D. F. Smith

"THAT the Traffic Accidents Committee investigate the setting up of a uniform, province-wide ambulance service, and that they also investigate the possibility that such a service could be run under the auspices of the St. John Ambulance Society." CARRIED.

AC115—Committee on Public Health (AR p. 26) Chairman, Dr. V. K. Rideout.

Dr. J. E. Hiltz, seconded by Dr. J. A. Smith, moved that this report be received for information.

AC116—During discussion of Para AR178 and AR179, Dr. Cantelope introduced Resolution AE'67 # 8 from the Annual Meeting of the Executive Committee: -

AE'67 # 8:

Moved by Dr. D. C. Cantelope

Seconded by Dr. J. A. MacPhail

"THAT WHEREAS, (1) the ten recommendations of the Committee on Public Health have been approved by our Executive and The Medical Society of Nova Scotia at our last Annual Meeting (1966), Resolution AC'66 # 60:

(2) WHEREAS the plans of routine employment and physical examinations are recommended and carried out in various industrial plants and occupations;

(3) and WHEREAS the Nova Scotia Hospital Insurance Commission has accepted as policy and suggested that those recommendations be implemented in full in every hospital;

(4) and WHEREAS, the Dept. of Public Health maintains officers and personnel in many hospitals; BE IT RESOLVED THAT the Dept. of Public Health be strongly urged to obtain and maintain the required health records of hospital employees as recommended in Item No. 10 of the Report of the Committee on Public Health 1966." CARRIED.

AC117—Discussion resulted in Resolution AC'67 # 32: -

AC'67 # 32:

Moved by Dr. D. C. Cantelope

Seconded by Dr. J. C. Wickwire

"THAT Resolution AE'67 # 8 be approved by Council." REJECTED.

During discussion prior to the vote, Dr. Stewart expressed the view that this was primarily a hospital responsibility. Dr. J. S. Robertson, Deputy Minister, expressed the view that the Dept. of Public Health would be pleased to assist the hospital in developing this plan but had no intention of taking it over.

AC118—The two recommendations contained in the report were then considered individually.

AC119—Recommendation No. 1—"That wider use be made of the tuberculin test by physicians." On motion of Dr. E. Ryan, seconded by Dr. H. C. Still, (**AC'67 # 33**), recommendation No. 1 was **adopted.**

AC120—Recommendation No. 2—"That new positive tuberculin reactors found should be reported to the Health Unit Director for contact investigation and follow-up." On motion of Dr. D. R. MacInnis, seconded by Dr. O. H. Millard, **AC'67 # 34**, recommendation No. 2 was **adopted.**

AC121—Committee on Mental Health (AR p. 77-78) Chairman, Dr. R. J. Weil.

In the absence of Dr. Weil, Dr. E. Ryan presented the report and moved, seconded by Dr. R. O. Jones, that Paras. AR391–400 be accepted for information. Paras. AR401-403 were also accepted for information. Para AR404 "It is recommended that the Dept. of Public Health, and especially Dr. Clyde Marshall, Administrator of Mental Health Services, should be credited by The Medical Society of Nova Scotia for this legislative innovation," was moved for adoption by Dr. C. B. Stewart, seconded by Dr. E. Ryan. CARRIED.

AC122—Further discussion resulted in Resolution AC'67 # 42: -

AC'67 # 42:

Moved by Dr. E. Ryan

Seconded by Dr. H. J. Bland

"THAT The Medical Society of Nova Scotia express its pleasure at the recent legislative innovation to include the Mental Hospitals of the Province under the terms of the Nova Scotia Hospital Services Commission, thus recognizing the psychiatric patient as medically ill. It is recommended that the Gov't. of the Province of Nova Scotia be so informed." CARRIED.

AC123—Committee on Pharmacy (AR p. 87-88) Chairman, Dr. A. F. Pasquet.

In the absence of the Chairman, Dr. S. C. Robinson presented the report under the following headings, each of which was dealt with separately:-

AC124—CHANGES IN DRUGS DISPENSED IN GOVERNMENT HOSPITALS. Moved by Dr. Robinson, seconded by Dr. Ryan, that the paras. AR446-449 be accepted for information. CARRIED.

AC125—The recommendations pertaining to this section of the report are included in paras. AR450-452 as follows: -

Para AR450—"That the wording and legal implication of this Committee's report of May 18/67 be reviewed and necessary changes, if any, made."

Para AR451—"That a copy of this Committee's corrected report of May 18/67 be forwarded to the National Committee, with all information available, and a request that it be studied and ultimately presented to the proper authorities for inclusion in the Federal Gov't. Purchase Act."

PARA. AR452—"That this Committee and the Executive Secretary go into the problem of implementing that report at the Provincial level."

AC126—Discussion resulted in Resolution AC'67 # 35: -

AC'67 # 35:

Moved by Dr. S. C. Robinson

Seconded by Dr. E. Ryan

"THAT Paras. AR450, AR451 & AR452 be adopted.', CARRIED.

AC127—CLINICAL RESEARCH WITHIN HOSPITALS: (AR453 & AR454). On motion, these paragraphs were **accepted for information.**

AC128—THE REPORT OF THE SPECIAL COMMITTEE APPOINTED BY THE DIRECTOR GENERAL OF THE FOOD AND DRUG DIRECTORATE AT THE RECOMMENDATION OF THE CANADIAN DRUG ADVISORY COMMITTEE TO ADVISE THE DIRECTORATE ON THE MISUSE AND ABUSE OF DRUGS IN CANADA. Para AR455. This paragraph and paragraph AR456 (Summary) were, on motion, accepted for information.

AC129—Paras. AR457-AR460 included some recommendations. Discussion of these resulted in Resolution AC'67 # 36: -

AC'67 # 36:
Moved by Dr. C. B. Stewart
Seconded by Dr. J. E. Hiltz
"THAT the report of the Committee on Pharmacy be referred back to that Committee." CARRIED.

AC130—The following resolution was then introduced: -

AC'67 # 37:
Moved by Dr. C. E. Kinley
Seconded by Dr. C. B. Stewart
"That the Pharmacy Committee consider the problems of Clinical Drug Trials, in conjunction with the Medical-Legal Liaison Committee." CARRIED.

AC131—**Committee on Occupational Medicine** (AR p. 22-23) Chairman, Dr. J. C. Wickwire.

Dr. Wickwire moved, seconded by Dr. Gorman, that paras. AR 65-70 be accepted for information.

AC132—**Discussion:** - Para AR65, which reads, "The report of the CMA Committee was discussed. We agree that it would be desirable to ensure that the standard CMA forms, called 'The Attending Physician's Statement', be kept confidential. It should be sent only to the Medical Department of the employer or the insurer.',

AC133—Dr. Saunders moved, seconded by Dr. Shears, that Paras. AR65, as amended, to Para AR70 be accepted for information. CARRIED.

AC134—There were three recommendations, each of which were considered individually.

AC135—**Recommendation No. 1:** - "That a plan of routine pre-employment and periodical physical examination, within industrial plants, be encouraged." Resulted in Resolution

AC'67 # 38:
Moved by Dr. J. C. Wickwire
Seconded by Dr. N. G. Glen
"THAT a plan of routine pre-employment and periodical physical examination for employees in industrial plants be encouraged." CARRIED.

AC136—**Recommendation No. 2:** - Resulted in Resolution **AC'67 # 39:** -
Moved by Dr. J. C. Wickwire
Seconded by Dr. J. A. Smith
"THAT Para AR71 (2) be approved. ("That the Saint John Ambulance program be extended to more industries within the Province.)" CARRIED.

AC137—**Recommendation No. 3:** - "That every effort be made to detect and to prevent early forms of occupational diseases - both major and minor." resulted in Resolution,

AC'67 # 40:
Moved by Dr. J. C. Wickwire
Seconded by Dr. D. C. Cantelope
"THAT Para AR71 (3) be adopted." CARRIED.

AC138—**Report of Nova Scotia Representative to C.M.A Executive** (AR p. 33-35) Chairman, Dr. A. J. M. Griffiths.

Dr. Griffith's report summarized three meetings of the C.M.A. Executive which he had attended. He referred to the appreciation of the C.M.A. for the work of Dr. R. O. Jones during his terms of office as a member of the C.M.A. Executive, President-Elect, President, and Past-President of the C.M.A. He also referred to the work of Dr. H. J. Devereux, who had been his predecessor on the C.M.A. Executive. Council expressed appreciation to these two members by applause. Dr. Griffiths moved, seconded by Dr. C. L. Gosse, that his report be received for information. CARRIED.

AC139—**Committee on Nutrition** (AR p. 97) Chairman, Dr. C. F. Brennan.

Dr. J. A. MacPhail presented the report which stated that investigation into the problem of anemia had been introduced by a study for evidence of iron deficiency in anemia in children admitted to a small general hospital for reasons other than blood dyscrasias or anemia.

AC140—On motion, paras. AR492-495 were accepted for information.

AC141—**Recommendation** (AR496) was proposed for adoption. Resolution AC'67 # 31 was presented: -

AC'67 # 31:
Moved by Dr. J. A. MacPhail
Seconded by Dr. W. A. Taylor
"THAT Para AR496 be approved with the deletion of the last 4 words - "whether appropriate or not'." CARRIED

AC142—The recommendation, as amended, reads: - "That all doctors who practice paediatrics pay more attention to the Blood Picture in young children, particularly the pale irritable child, and treat all children with aemia."

AC143—**Report of Medical-Legal Liaison Committee** (AR p. 17-20) Chairman, Dr. I. Maxwell.

Dr. Maxwell presented his report which related progress during the past year in the analysis of breath alcohol, medical legal inquiries, a proposed joint course of instruction in Forensic Medicine by the Faculties of Medicine and Law and a Medical-Legal Panel on Therapeutic Abortion which had taken place at the Summer Meeting 1967. He also reported that during the year, "The Evidence Act", "The Treatment of Sexual Deviates" and "Legal Definition of Death" had been studied.

AC144—On motion by Dr. Maxwell, seconded by Dr. R. O. Jones, paras. AR41-AR62 inclusive were received for information.

AC145—Two recommendations were considered individually: -

Para (AR63) "That the Committee on Medical-Legal Liaison continue in existence."

Para (AR64) "That the Committee hold itself available to discuss joint problems between the Nova Scotia Barrister's Society and The Medical Society of Nova Scotia as they arise."

AC146—**Discssion** resulted in Resolution AC'67 # 41: -

AC'67 # 41:
Moved by Dr. C. L. Gosse
Seconded by Dr. F. A. Dunsworth
"THAT Para. AR63 & AR64 be adopted." CARRIED.

AC147—**Committee on Annual Meeting,** Chairman, Dr. G. McK. Saunders.

Dr. Saunders gave a verbal report stating that the Council and Annual Meetings for 1968 would be held at the

Lord Nelson Hotel and that the Summer Meeting 1968 would be held at The Pines, Digby, on July 4th, 5th & 6th, 1968. He reported that consideration was being given to having the Summer Meeting of 1969 in Bermuda or Barbados and that the Executive Committee directed that more information should be obtained on this. He also reported that the Annual Meeting of the C.M.A. would be held in Regina on June 17th-21st, 1968.

AC148—On motion, this verbal report was accepted for information.

AC149—**Committee on Public Relations** (AR p. 91), Chairman, Dr. O. H. Millard.

Dr. Millard presented his report reviewing the work of the last year. A meeting had been convened to explore the possibility of creating a formal list of "Oppportunities for Practice in Nova Scotia," but there had been no subsequent meeting on this subject.

AC150—Dr. Millard moved, seconded by Dr. F. G. Bell, that Paras. AR470-AR475 be received for information. CARRIED.

AC151—At this point, the Chairman Dr. Saunders drew the attention of Council to the Annual Reports of Committees and Representatives which had not been presented to Council as follows:

Representatives to Provincial Medical Board: Dr. J. A. Myrden

Committee on Insurance: Dr. E. B. Grantmyre
Committee on Archives: Dr. D. R. MacInnis
Committee on Aging: Dr. Peter Gordon
Committee on Rehabilitation: Dr. A. A. Macdonald
Committee on Civil Disaster: Dr. S. B. Bird
Committee on Physical Education & Recreation: Dr. J. K. Purves
Committee on Mediation & Discipline: Dr. G. MeK. Saunders
Federal & Provincial Health Grants: Dr. C. J. W. Beckwith
Trusteeship Committee (C.M.A.) C.M.R.S.P. and C.M.E.F.: Dr. C. L. Gosse
Canadian Cancer Society (N.S. Division): Dr. J. A. Myrden
Medical Advisory Board, Nova Scotia Tuberculosis Association: Dr. B. C. Trask
Dalhousie Medical Library: Dr. D. E. Lewis
V.O.N. Board of Governors & Medical Advisory Committee: Dr. G. M. Smith
Board of Registration, Certified Nursing Assistants: Dr. J. A. MacCormick
Provincial Liaison Committee on Nursing: Dr. R. M. MacDonald
Medical Advisory Committee on Drivers Licensing: Dr. A. J. MacLeod, Dr. H. K. Hall
Board of Examiners, Social Workers: Dr. R. O. Jones
Section for General Practice: Dr. D. C. Brown

AC152—Council agreed that these reports be accepted for information and referred to the Executive Committee.

AC153—**New Business:**

Resolution AC'67 # 7, which had been introduced but not discussed at the 1st Session of Council is now presented.

Resolution **AC'67 # 7:**

Moved by Dr. D. C. Brown

Seconded by Dr. N. G. Glen

"THAT whereas there exists in Nova Scotia an apparent need for close medical-legal-religious liaison and,

WHEREAS, modern medical advances have created a whole new area of complex, diversified, ethical and moral problems that require further study and clarification, and

WHEREAS, there is a growing trend to community medicine that utilizes many of the varied trained personnel and facilities that exist in each community, and

WHEREAS the care of patients by physicians and clergy often overlap, and

WHEREAS society continuously develops new situations for which no precedents exist,

BE IT RESOLVED THAT (1) a committee on Medicine and Religion be formed in The Medical Society of Nova Scotia; and (2) that it be recommended that the C.M.A. study the advisability and feasibility of a committee on Medicine and Religion of the C.M.A." CARRIED.

AC154—**Discussion** resulted in Resolution AC'67 # 43: -

AC'67 # 43

Moved by Dr. C. L. Gosse

Seconded by Dr. D. R. MacInnis

"THAT Resolution AC'67 # 7 be referred to the Executive Committee." CARRIED.

AC155—Dr. G. C. Jollymore referred to Resolution AC'67 # 20 arising from the report of the Committee on Membership, namely: "That membership in The Medical Society of Nova Scotia be compulsory for all licensed physicians in Nova Scotia" and expressing the view that the word "Society" means voluntary, presented the following Resolution: -

AC'67 # 44:

Moved by Dr. G. C. Jollymore

Seconded by Dr. Langille

"THAT the name of The Medical Society of Nova Scotia be changed to a more appropriate one which will not give the false impression that it is a voluntary organization, and that a name change be implemented before Resolution # 20 has been put into effect."

AC156—During discussion, Dr. T. W. Gorman moved, seconded by Dr. C.L. Gosse, that the above resolution (AC67 No. 44) be referred to the Executive Committee. CARRIED.

AC157—On motion, the 3rd Session of Council was adjourned at approximately 12:55 p.m.

Lord Nelson Hotel and that the Summer Meeting 1968 would be held at The Pines, Digby, on July 4th, 5th & 6th, 1968. He reported that consideration was being given to having the Summer Meeting of 1969 in Bermuda or Barbados and that the Executive Committee directed that more information should be obtained on this. He also reported that the Annual Meeting of the C.M.A. would be held in Regina on June 17th-21st, 1968.

AC148—On motion, this verbal report was accepted for information.

AC149—**Committee on Public Relations** (AR p. 91), Chairman, Dr. O. H. Millard.

Dr. Millard presented his report reviewing the work of the last year. A meeting had been convened to explore the possibility of creating a formal list of "Oppportunities for Practice in Nova Scotia," but there had been no subsequent meeting on this subject.

AC150—Dr. Millard moved, seconded by Dr. F. G. Bell, that Paras. AR470-AR475 be received for information. CARRIED.

AC151—At this point, the Chairman Dr. Saunders drew the attention of Council to the Annual Reports of Committees and Representatives which had not been presented to Council as follows:

Representatives to Provincial Medical Board: Dr. J. A. Myrden

Committee on Insurance: Dr. E. B. Grantmyre
Committee on Archives: Dr. D. R. MacInnis
Committee on Aging: Dr. Peter Gordon
Committee on Rehabilitation: Dr. A. A. Macdonald
Committee on Civil Disaster: Dr. S. B. Bird
Committee on Physical Education & Recreation: Dr. J. K. Purves
Committee on Mediation & Discipline: Dr. G. MeK. Saunders
Federal & Provincial Health Grants: Dr. C. J. W. Beckwith
Trusteeship Committee (C.M.A.) C.M.R.S.P. and C.M.E.F.: Dr. C. L. Gosse
Canadian Cancer Society (N.S. Division): Dr. J. A. Myrden
Medical Advisory Board, Nova Scotia Tuberculosis Association: Dr. B. C. Trask
Dalhousie Medical Library: Dr. D. E. Lewis
V.O.N. Board of Governors & Medical Advisory Committee: Dr. G. M. Smith
Board of Registration, Certified Nursing Assistants: Dr. J. A. MacCormick
Provincial Liaison Committee on Nursing: Dr. R. M. MacDonald
Medical Advisory Committee on Drivers Licensing: Dr. A. J. MacLeod, Dr. H. K. Hall
Board of Examiners, Social Workers: Dr. R. O. Jones
Section for General Practice: Dr. D. C. Brown

AC152—Council agreed that these reports be accepted for information and referred to the Executive Committee.

AC153—**New Business:**

Resolution AC'67 # 7, which had been introduced but not discussed at the 1st Session of Council is now presented.

Resolution **AC'67 # 7:**

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WHEREAS, modern medical advances have created a whole new area of complex, diversified, ethical and moral problems that require further study and clarification, and

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Seconded by Dr. D. R. MacInnis

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Nominating Committee (1967-1968) to report to the 115th Annual Meeting, November 22nd and 23rd, 1968.

Antigonish-Guysborough	— Dr. C. N. MacIntosh Alternate Dr. Rolf Sers
Cape Breton	— Dr. N. F. Macneill Alternate Dr. Harold Davidson
Colchester-East Hants	— Dr. T. C. C. Sodero Alternate Dr. M. Bruce
Cumberland	— Dr. H. Christie Alternate Dr. D. R. Davies
Dartmouth	— Dr. F. J. Barton Alternate Dr. Graham Pace
Eastern Shore	— Dr. M. Trivedi No alternate recorded
Halifax	— Dr. B. J. Steele Alternate Dr. D. Howell
Inverness-Victoria	— (no record) Alternate (no record)
Lunenburg-Queens	— Dr. S. B. Bird Alternate Dr. A. J. M. Griffiths
Pictou County	— Dr. R. G. Munroe Alternate Dr. C. Young
Shelburne	— Dr. W. H. Jeffrey Alternate Dr. A. S. Robbins
Valley	— Dr. D. J. G. Morris Alternate: (no record)
Western N. S.	— Dr. M. W. O'Brien Alternate Dr. R. P. Belliveau

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 114th Annual Meeting was adjourned at approximately 7.00 p.m.

SECOND SESSION

Saturday, November 25th 1967.
1.00 p.m.

Hotel Nova Scotian, Halifax

AM4—Following adjournment of the 1967 Council, the President, Dr. G. McK. Saunders, asked members whether the 2nd Session of the Annual Meeting should be convened now or after lunch: it was agreed by all that it should be convened immediately.

The President convened the 2nd Session of the Annual Meeting 1967 at 1.05 p.m.

AM5—Dr. Griffiths moved, seconded by Dr. Gorman, that Para AR426 under the Annual Report of Maternal and Perinatal Health be accepted. (Para AR426 reads: - "I wish to thank all members of this Committee for their interest, knowledge, and time they have given to the work of the Committee. I especially wish to bring to the attention of the Medical Society, the Perinatal Mortality report 1966 which has been prepared by Dr. Kenneth Scott, Assistant Professor of Paediatrics, and member of the Nucleus Committee. I wish to thank Mrs. Lorraine Murphy, secretary of the project for her most capable industry during 1966. Also, thanks to Mrs. Barbara Muldowney, coding clerk for the project."

AM6—Dr. Hiltz proposed we accept all resolutions passed through Council Sessions except the ones to be referred to the Executive Committee. This was seconded by Dr. Devereux.

AM7—Dr. Beckwith moved, seconded by Dr. C. B. Stewart, that Chapter 16 of the By-Laws be examined by the incoming Executive.

AM8—Dr. MacPhail questioned the Press being invited to the Council Meetings. After discussion, a resolution was passed as follows: -

AM'67 No. 1:
Moved by Dr. J. A. MacPhail
Seconded by Dr. J. A. Smith
"THAT the matter of press representation at Council be referred to the Executive Committee for consideration, in view of the fact that the decisions of Council are not the final decisions of the Society but subject to the final approval of the Annual Meeting." CARRIED.

A-9—Dr. Wickwire said he felt the P.S.I. Committee had been doing wonderful work. Council members agreed heartily.

AM10—Resolution AM'67 No. 2 was brought forward: -

AM'67 No. 2:
Moved by Dr. A. J. M. Griffiths
Seconded by Dr. H. J. Devereux
"THAT the Transactions and Resolutions of the 3rd Meeting of Council of the Medical Society be approved by this Annual Meeting." CARRIED.

AM11—There being no further business, the President asked for a motion to adjourn the Meeting.

AM12—The 114th Annual Meeting of The Medical Society of Nova Scotia was adjourned at 1.30 p.m. □